HARVARD
School of Dental Medicine

2019-2020 Application for Financial Aid Appeal

Student Name _____

Social Security # xxx-xx-_____ OR HUID # _____

1. Student Household Information

*Please provide information about your **custodial** parent information below. If your custodial parent is remarried, please provide your step-parent information as well.*

Parent Marital Status

Indicate your custodial parent(s)' current marital status and status date

Married ___ Date _____ Divorced ___ Date _____ Remarried ___ Date _____

Separated ___ Date _____ Widowed ___ Date _____ Single ___

Father/Step-Father Name _____ Birth Date _____

Mother/ Step-Mother Name _____ Birth Date _____

Provide information about the members of your parent(s)' household for whom your parent(s)' will provide at least 50% of the financial support between July 1st, 2019 and June 30th, 2020. Include yourself, your parents/step-parents and any other members of the household who will reside in the household between July 1st, 2019 and June 30th, 2020.

Name	Age	Relationship to You	Name of College/University Attending at Least Half-time for 2019-20

If necessary, please indicate any additional relevant information about your household on an attached page.

2. Parent/Step-Parent Financial Information

Indicate the total amount projected for the 2019 tax year from the following sources. If no amount is expected, please enter "0".

2019 Projected Income Information

Adjusted Gross Income	$	Taxes Paid	$
Wages/Salaries/Tips Father/Step-Father	$	Wages/Salaries/Tips Mother/Step-Mother	$
Bank Interest	$	IRA/Pension Distributions	$
Dividends	$	Social Security Payments	$
IRA/Keogh Payments	$	AFDC	$
Business Income	$	Unemployment Compensation	$
Farm Income	$	Alimony Received	$
Annuities	$	Other Taxable Income	$

Untaxed Income

Indicate any income projected from the following between January 1st, 2019 and December 31st, 2019

Child Support Received	$	Veterans Non-Education Benefits	$
Worker's Compensation	$	Combat Pay	$
Untaxed IRA/Pension Benefits	$	Clergy Housing Allowance	$
Payments to IRA/Pension Accounts	$	Other Untaxed Income	$

Asset Information

*Indicate the **net** value (as of the current date) of the following. If there is no value for a listed item, please enter "0".*

Cash/Savings/Checking Accounts	$	Trust Funds	$
Money Market Accounts	$	Mutual Funds	$
Stocks	$	Bonds	$
Net Home Value	$	Other Securities	$
Business/Farm Value*	$	Other Real Estate**	$
College Savings Plans	$	Other	$

* If you own more than 50% of the business AND the business employees less than 100 full-time equivalent employees, enter "0". If your farm is your primary residence, enter "0".

** Only include real estate that is not your primary residence

3. Additional Information

Please include an explanation of the circumstances surrounding your appeal. If necessary, please continue and attach additional sheets.

4. Certification

By signing this form, I (we) certify all information reported to the Office of Financial Aid is complete and accurate.

Student Signature Date

Parent Signature Date

Please complete, sign and return this form by faxing it to 617.432.3881 or mailing it to the address listed below. Questions? Call us at (617) 432.1527or email gardner_key@hsdm.haravard.edu.

Harvard School of Dental Medicine

Office of Financial Aid

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Boston, MA 02115