

# HARVARD

## School of Dental Medicine

### 2019-2020 Verification Worksheet

Your application for financial aid has been selected for a process called "Verification". Through the Verification process, Financial Aid will be corroborating information submitted on your 2019-2020 Free Application for Federal Student Aid (FAFSA) with information you submit on this Verification Worksheet. U.S. Department of Education policy indicates the Office of Financial Aid has the legal authority to require you to submit the indicated information prior to providing you with a financial aid award. Please contact Financial Aid at 617.432.1527 if you would like assistance completing this form.

#### Student Information:

Student Name \_\_\_\_\_

Social Security # xxx-xx- OR HUID # \_\_\_\_\_ Date of Birth \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Street Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Email Address \_\_\_\_\_ Phone Number (\_\_\_\_) \_\_\_\_\_

#### Household Information

Indicate *your* marital status (check one):

Single  Married (includes remarried)  Separated/Divorced  Widowed

**Please Note:** If you were married on the day you filed your Free Application for Student Aid (FAFSA) you must include a copy of your spouse's 2017 Tax Return Transcript even if you were not married during the 2017 tax year.

**In the table below, write the names of all the members of your household:**

1. Include **your name** and **your spouse** (if you are married).
2. Include your children, if you will provide more than half of their support from July 1, 2019 to June 30, 2020.
3. Include other people if they now live with you, and you provide more than half of their support and will continue to provide more than half of their support from July 1, 2019 to June 30, 2020.
4. Also, **include the name of the college for any household member, excluding your parents, who will be attending college at least half-time** (at least 6 credit hours) from July 1, 2019 to June 30, 2020, and will be enrolled in a degree or certificate program. If you require more space, attach a separate page.

Name	Relationship to Student	Enrolled in College during 2019-20	Will enroll at least half-time?	Expected Year of Graduation
	Self	HSDM	Yes	

#### Student and Spouse (if applicable) Tax Information

Office of Financial Aid  
 188 Longwood Ave., Boston, MA 02115 Phone: 617.432.1527 Fax: 617.432.3881  
[www.hsdm.harvard.edu](http://www.hsdm.harvard.edu)

1. Check **only one** of the boxes below:

I did file a 2017 Federal Income Tax Return.

I did not file and I am not required to file a 2017 Federal Income Tax Return.

Please complete the following (if \$0, enter \$0):

Student's Wages: \_\_\_\_\_ Spouse's Wages: \_\_\_\_\_

Student's Employer(s): \_\_\_\_\_ Spouse's Employer(s): \_\_\_\_\_

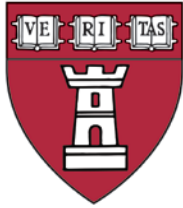
**Please Note: If you earned more than the figures listed below you are required to file a 2017 Federal Income Tax Return.**

Filing Status	Income	Filing Status	Income
Single	\$10,400	Married Filing Jointly	\$20,800
Head of Household	\$13,400	Married Filing Separately	\$4,050
Qualifying Widow(er)	\$16,750	Single Dependent	\$6,350

**Student and Spouse (if applicable) Untaxed Income Information**

	Total 2017 Untaxed Income		Source of Information - Your Own Records, or:
	Student	Spouse	
Child Support <b>Received</b> for all children within household for calendar year 2013 ( <b>entire year</b> )	\$	\$	MA Child Support Customer Service Bureau 1-800-332-2733 (for MA Residents only)
Veterans Non-Education Benefits (Disability, Death Pension, DIC) for calendar year 2013 ( <b>entire year</b> )	\$	\$	US Department of Veterans Affairs 1-800-827-1000
Worker's Compensation for calendar year 2013 ( <b>entire year</b> )	\$	\$	Appropriate Supporting Documentation
Other Untaxed Income/ Benefits Not Listed Above for calendar year 2013 ( <b>entire year</b> )	\$	\$	Student Source: _____  Spouse Source: _____

Child Support <b>Paid by You (or your spouse, if married)</b> Do Not Include Support for Children in Your Own Household for calendar year 2017 ( <b>entire year</b> )	Paid To:
	On behalf of:
	1.
	2.
	3.
	4.
Total: \$	



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### Statement of Educational Purpose

**I certify that I am the individual signing this Statement of Education Purpose and that the Federal student financial assistance I may receive will only be used for educational purposes and to pay the cost of attending the Harvard School of Dental Medicine for 2017-18.**

Student's Signature \_\_\_\_\_ Date \_\_\_\_\_

### Certification

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

Student's Signature \_\_\_\_\_ Date \_\_\_\_\_

Spouse's Signature (if student is married) \_\_\_\_\_ 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 617.432.1527.