

Request for Forbearance/Hardship/Unemployment Deferment

I understand that all information and supporting documents given will be held in strictest confidence and will not be subject to dissemination outside the requirements of the lending institution. I further understand that this arrangement will consist of reduced or deferred payments, as determined by the lending institution based on my financial situation. It may be necessary to make accelerated payments at the expiration of this arrangement to repay the loan within the maximum ten-year period.

Borrower's Name/Address:

Mail form to: University of Kansas Medical Center
3901 Rainbow Bld MS-4008
Kansas City, KS 66160

Email Address:

Account Number:

Section 1 Applicable Benefits

Benefit types 1 and 2: Applicable to federal Perkins, Nursing/Health profession, and selected Institutional loans.
Benefit types 3 and 4: Applicable to Perkins loans.

Benefit type 1 – I request forbearance on my Perkins loans because (Select one from A-D & check 1 or 2 on E):

(A) ___ My title IV SFA loan payments are equal to or greater than 20% of my total monthly income. (Complete section 2 and 3)

(B) ___ I am unable to make scheduled payments due to 'Poor Health' (temporarily – totally disabled). (complete section 2 and 4)

(C) ___ Caring for a **dependent** who is disabled. (Complete section 2 and 4)

(D) ___ Other acceptable reason: _____ (Complete section 2)

(E) Interest continues to accrue during this benefit type. For interest payment (1) ___ bill me monthly (2) ___ bill me at end of my benefit.

(We recommend paying interest monthly to avoid a lump sum payment at the end of this benefit type or forbearance)

Benefit type 2 – I request a Temporary reduction of my monthly loan payment:

Based on my financial situation, I will make monthly payments in the amount of \$ _____ for a period of _____ months. If approved, I agree to make repayment of this amount each month as a condition of this agreement, and that if payment is not made, my agreement may be terminated by the school. (Complete section 2 and 3)

Benefit type 3 – I request economic hardship deferment because:

(A) ___ I have been granted economic hardship for William D. Ford Federal Direct Student Loan (FDSL) or Federal Family Education Loan (FEEL) for the current period of time. **(Satisfactory documentation is required)**

(B) ___ I am receiving payment under Federal or State Public Assistance. (AFDC, Supplemental Security income, Food Stamps, or State Public Assistance). (Complete section 2 and 3)

(C) ___ My title IV SFA loan payments are equal to or greater than 20% of my total monthly income, and my monthly gross income minus my Title IV loan payments is less than 220% of the earnings of individuals on minimum wage, or 100% of the poverty income for a family of two. (Complete section 2 and 3)

Benefit type 4 – I request an unemployment deferment for a period of _____ month(s).

1. I am currently unemployed and actively seeking employment. In order to verify that I am actively seeking employment, I must register with an employment agency and have this form certified.

2. Certification by employment agency: Please complete the following and affix seal or stamp with agency name or attach letter verifying individual's original registration date with agency.

I, _____, certify that the above-mentioned individual has been duly registered with this employment agency.

Agency Name _____ Address _____

City _____ State _____ Zip _____ Phone number _____

Section 2 Borrower Certification

I certify that all statements made are true and correct. I also certify that I will immediately notify the lending institution of any change in my employment status or significant change in my financial situation. I authorize a representative of the lending institution to obtain from my applicable parties' pertinent information in order to verify this application. Final responsibility for completion and return of this form to the institution rests with the borrower. This account will remain in status quo until this form is approved if this form is incomplete; it will be returned to the borrower.

Signature _____ SS Number _____ Date _____

Day Phone _____ Evening Phone _____ Cell Phone _____

Marital Status _____ Dependents – Number _____ Age(s) _____

Please list the name, address, and phone number of someone who will always know your whereabouts:

Name _____

Address _____

Day Phone _____ Evening Phone _____ Cell Phone _____

Institutional Action

Date _____ - _____ Approved _____ Disapproved _____ Official _____ Date _____

Section 3 Income and Expenses

My Monthly Income

* _____ Gross Wages
 * _____ Spouse's
 ** _____ Public Assistance
 ** _____ Unemployment
 ** _____ Child Support
 ** _____ Other Income
 ** _____ Workmen Comp
 \$ _____ **Total**

Student Loan Information

Type	Loan Amt	Mthly Pmt
* _____	\$ _____	\$ _____
* _____	\$ _____	\$ _____
* _____	\$ _____	\$ _____
* _____	\$ _____	\$ _____
* _____	\$ _____	\$ _____
* _____	\$ _____	\$ _____
Total	\$ _____	\$ _____

*PLEASE FURNISH CHECK STUB **PLEASE FURNISH EVIDENCE

Section 4 Statement of Disability (Completed by Physician)

Patient's Name: _____ Subjective symptoms: _____
 Relationship to Borrower: _____ Objective Symptoms: _____
 Date when symptoms first appeared: _____ Diagnosis: _____
 Date accident occurred: _____ **If needed please attach a separate sheet of paper**

Treatment

First visit date _____ Last visit date _____ Frequency of visit (Weekly, Monthly, Other) _____

Progress

Present condition: Recovered _____ Unchanged _____ Improved _____ Retrogressed _____
 Is patient: Ambulatory _____ Bed Confined _____ House Confined _____ Hospital Confined _____

Extent of Disability

Is patient 'NOW' totally disabled for
 If no, when is or was the patient able to go to work
 Will patient be able to resume any work
 Indefinite
 Never

Any Occupation		Regular Occupation	
YES _____	NO _____	YES _____	NO _____
MM/DD/YY _____		MM/DD/YY _____	
MM/DD/YY _____		MM/DD/YY _____	
YES _____	NO _____	YES _____	NO _____
YES _____	NO _____	YES _____	NO _____

If yes, is patient a suitable candidate for rehabilitation Yes _____ No _____

Physician Name _____ Physician License Number _____
 Address _____
 City _____ State _____ Zip _____
 Phone Number _____ Fax number _____ Date _____
 Attending Physician Signature _____