

# 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:

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.

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**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)\_\_\_ I am enrolled in a course of study that is part of Department approved **rehabilitation** training program for disabled individuals.  
(Complete sections 2 and 4)

(D)\_\_\_ Caring for a **dependent** who is disabled. (Complete section 2 and 4)

(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)**

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**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)

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**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)

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**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:

I certify that the above-mentioned individual has been duly registered with this employment 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
_____	\$_____	\$_____
_____	\$_____	\$_____
_____	\$_____	\$_____
_____	\$_____	\$_____
_____	\$_____	\$_____
_____	\$_____	\$_____
<b>Total</b>	\$_____	\$_____

\*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\_\_\_\_\_ Address\_\_\_\_\_

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

Phone Number\_\_\_\_\_ Fax number\_\_\_\_\_

Date\_\_\_\_\_ Attending Physician Signature\_\_\_\_\_