

PLEASE SELECT THE APPLICABLE BENEFIT(S) :

BENEFIT TYPES 1 AND 2 : APPLICABLE TO FEDERAL PERKINS, NURSING/HEALTH PROFESSION, SELECTED INSTITUTIONAL LOANS.

BENEFIT TYPES 3 AND 4 : APPLICABLE TO PERKINS LOANS ISSUED 7/1/93 AND AFTER.

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.

MAIL FORM TO :
JOHN CARROLL UNIVERSITY
BOX 5780-N

CLEVELAND OH 441930565
(216) 397-4271
ACCOUNT NUMBER :

SECTION 1 - APPLICABLE BENEFITS

- BENEFIT TYPE 1 - I REQUEST FOREBEARANCE ON MY PERKINS LOANS BECAUSE:**
 - (A) _____ MY TITLE IV SFA LOAN PAYMENTS ARE EQUAL TO OR GREATER THAN 20% OF MY TOTAL MONTHLY PAYMENTS.
(COMPLETE SECTION 2 AND SECTION 3)
 - (B) _____ I AM UNABLE TO MAKE SCHEDULED PAYMENTS DUE TO 'POOR HEALTH'.
(COMPLETE SECTION 2 AND SECTION 4)

- 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)

- BENEFIT TYPE 3 - I REQUEST ECONOMIC HARDSHIP BECAUSE :**
 - (A) _____ I HAVE BEEN GRANTED ECONOMIC HARDSHIP FOR FDSL OR FFEL FOR THE CURRENT PERIOD OF TIME.
 - (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 SECTION 3)

- BENEFIT TYPE 4 - I REQUEST AN UNEMPLOYMENT DEFERMENT FOR A PERIOD OF _____ MONTHS.**
 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. PLEASE LIST THE NAME, ADDRESS, AND PHONE NUMBER OF SOMEONE WHO WILL ALWAYS KNOW YOUR WHEREABOUTS:
NAME _____
ADDRESS _____
PHONE _____
 3. **CERTIFICATION BY EMPLOYMENT AGENCY :**
I CERTIFY THAT THE ABOVE MENTIONED INDIVIDUAL HAS BEEN DULY REGISTERED WITH THIS EMPLOYMENT AGENCY.
NAME _____ ADDRESS _____
CITY _____ STATE _____ ZIP _____
AGENCY SIGNATURE _____ DATE _____ PHONE _____

SECTION 2 - BORROWER CERTIFICATION

I certify that all statements made are true and correct. I also certify that I will immediately notify the lending institut. 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 _____ Date _____

INSTITUTIONAL ACTION

_____ APPROVED _____ DISAPPROVED _____ Official _____ Date _____

SECTION 3 - INCOME AND EXPENSES

MY MONTHLY INCOME

MY MONTHLY EXPENSES

* _____ NET WAGES	*** _____ HOUSING
* _____ SPOUSE'S WAGES	*** _____ FOOD
** _____ PUBLIC ASSISTANCE	*** _____ UTILITIES _____ PHONE
** _____ UNEMPLOYMENT COMPENSATION	*** _____ BANK LOANS _____ CREDIT CARDS
** _____ CHILD SUPPORT	*** _____ CAR PAYMENT _____ CAR EXPENSES
** _____ OTHER INCOME	*** _____ MEDICAL -(NOT COVERED BY INSURANCE
\$ _____ TOTAL	\$ _____ TOTAL

* PLEASE FURNISH CHECK STUB ** PLEASE FURNISH EVIDENCE *** PLEASE FURNISH COPIES OF BILLS

SECTION 4 - STATEMENT OF DISABILITY (COMPLETED BY PHYSICIAN)

DATE WHEN SYMPTOMS FIRST APPEARED OR ACCIDENT OCCURED (MM/DD/YY) _____

SUBJECTIVE SYMPTOMS :

OBJECTIVE SYMPTOMS :

DIAGNOSIS :

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

	ANY OCCUPATION	REGULAR OCCUPATION
IS PATIENT 'NOW' TOTALLY DISABLED FOR -----	YES _____ NO _____	YES _____ NO _____
IF NO, WHEN WAS PATIENT ABLE TO GO TO WORK -	MM/DD/YY _____	MM/DD/YY _____
WILL PATIENT BE ABLE TO RESUME ANY WORK . -	MM/DD/YY _____	MM/DD/YY _____
INDEFINITE -	YES _____ NO _____	YES _____ NO _____
NEVER -	YES _____ NO _____	YES _____ NO _____
IF YES, IS PATIENT A SUITABLE CANDIDATE FOR REHABILITATION	YES _____ NO _____	YES _____ NO _____

PHYSICIAN NAME _____ ADDRESS _____

CITY _____ ST _____ ZIP _____ PHONE _____

DATE _____ ATTENDING PHYSICIAN SIGNATURE _____