Appeal for Special Circumstance

Please mail directly to:
Hawaii Community College
Financial Aid Office
200 W. Kawili Street
Hilo, Hawaii 96720-4091

HawCC Appeal for Special Circumstance for the __________ Award Year.

Student's Name: ____
Last First M.I.

Banner ID or SSN: ____

SECTION A – LOSS OF INCOME

Please circle whose income changed:

Student Spouse Student's Mother Student's Father

When did the change in income occur? ____

Why did the change in income occur (e.g. lay off, injury, quit, etc.)?

____

____

Is the reduction or loss of income temporary? Yes No

If yes, expected duration of reduction/loss. ____

From ______________________ To ______________________
(MM/DD/YYYY) (MM/DD/YYYY)

Documentation of change to income must be documented. Please attach supporting documentation of the change to income to this form.

Examples of Documentation Required:

Termination of employment must be supported with documentation as to date unemployment began, the nature of termination (e.g. layoff, quit), reason for any voluntary termination, and the Unemployment Benefit Statement showing the decision, the start and end dates, and the amount of benefits.

Death of spouse or parent can be documented by death certificate, obituary, or other official document.

Injury can be documented by doctor or hospital reports and employer statement that injury resulted in loss of employment or reduced hours of employment (if not a permanent loss of employment, expected duration statement is required). Workers' Compensation Benefits Determination must be submitted if benefits are being received.

Other documentation may be required.

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SECTION B – MEDICAL OR DENTAL EXPENSE

Adjustments are only made for significant medical or dental expenses that are not covered by insurance and have been paid by an Independent student and/or his/her spouse or a Dependant student and his/her parent.

Please circle who paid the medical or dental expense:

Student Spouse Student's Mother Student's Father

Please attach documentation of paid medical or dental expense and sign the certification below:

I, ______________________ , hereby certify that medical and/or dental expenses submitted with
Name
this appeal are not covered by any type of insurance and no reimbursement for these expense will be received.

______________________ ______________________
Signature Date

SECTION C – OTHER

Please write a brief description of other income/expense adjustment requested. The description must be specific as to person affected, amount of adjustment requested, and reason for adjustment request. The request must be accompanied by supporting documentation.

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Signatures (required for all parties named in the appeal)

______________________ ______________________
Student Date

______________________ ______________________
Spouse Date

______________________ ______________________
Mother Date

______________________ ______________________
Father Date