

2019-20 FINANCIAL AID REQUEST MEMO

Tufts University School of Medicine
Financial Aid Office
136 Harrison Avenue
Boston, MA 02111
Telephone# (617) 636-6574 Fax# (617) 636-3447
Med-finaid@tufts.edu

Student Name _____ Tufts ID # _____

Telephone # () _____ Year of Graduation _____

Please note that per federal regulations, all loan disbursements must be evenly split between semesters. For new loans disbursed after October 1, 2019, a net origination fee is deducted of 1.059% for Direct Unsubsidized Loans and 4.236% for Direct Grad PLUS loans.

I request that the Office of Financial aid:

Increase my loan by \$ _____
Please indicate amount above is: GROSS (before fees) or NET (after fees)

Decrease my loan by \$ _____ for the following semester: Fall Spring Summer
Please indicate amount above is: GROSS (before fees) or NET (after fees)

From my: Unsubsidized Loan Grad PLUS Loan
 Other Loan (specify loan name) _____

Please note: The Office of Financial Aid will only accept voluntary requests to decrease loans for the current semester IF:

- 1. There are funds available on your student account to return to the lender AND*
 - 2. Your loan had disbursed less than 120 days prior to the request.*
- OR*
- 3. You have a future disbursement that we are able to adjust but this must be noted above by checking off the applicable semester.*

Please note: It is the student's responsibility to ensure that funds have been returned and/or disbursed. Please contact the Office of Financial Aid and/or view SIS for confirmation within 10 days of submitting.

Federal Work Study: Increase amount by: _____ Decrease amount by: _____
I understand that increasing my work study may reduce my loan eligibility

Additional Comments:

Student Signature: _____ Date _____

Financial aid office use:

Completed by _____

Revised Financial Aid Notice Sent Date: _____