(STMED) SCCF Medical/Dental Expense Addendum

2024-2025

University of South Florida
Office of Financial Aid • 4202 East Fowler Avenue, SVC 1102 • Tampa, Florida 33620-6960

Student's Name: _____ USF ID: U ____ ____ ____ ____ ____ ____ ____ ____

- This form, along with any attachments, must be completed and submitted to OFA no later than **June 30, 2025.**
- Insurance premiums are not considered a medical/dental expense for the purpose of this form.
- Over-the-counter medications and/or elective/cosmetic procedures cannot be included.
- Only copies of documents should be submitted. Keep any originals for your own records, as they cannot be returned.
- Expenses can only be for spouse/dependents. Student expenses CANNOT be included.

The uninsured medical expenses must have been included as itemized deductions on the student's Tax Return in the tax year the expenses incurred. Medical expenses must exceed the standard deductions for that tax year:

Tax Filing Status	2022 Standard Deductions	2023 Standard Deductions	2024 Standard Deductions
Single	$12,950	$13,850	$14,600
Head of House Hold	$19,400	$20,800	$21,900
Married Filing Jointly	$25,900	$27,700	$29,200
Married Filing Separately	$12,950	$13,850	$14,600

Instructions:

- Any additional sheets needed for expenses should match formatting of table below and attached to this form.
- Attach copies of receipts for **paid** bills. The following documents are **not** acceptable:
  - Explanation of benefits letters
  - Cancelled checks
  - Self-written verification of payments
  - If insurance paid bill or reimbursed you, it will not be accepted.
- For each receipt:
  - Write number on top right corner of receipt.
    - This number should also be written on table in "Receipt Number" box.
  - Circle the paid amount and the date on the receipt or documentation.
    - Use black ink only. Do not use highlighters.
    - Write date in date box in row that matches receipt number.
    - Write total bill amount and the amount you paid (but were not reimbursed) in appropriate box.
  - Write name of doctor/hospital in box that matches receipt number.
    - If name is not apparent on bill, documentation must be provided alongside (which includes information showing corresponding bill)
- If treatment received can be considered elective/cosmetic, a statement explaining medical necessity must be submitted.
- The back of this document must be signed.

YEAR OF MEDICAL EXPENSES MUST MATCH YEAR OF UPDATED FINANCIAL INFORMATION ON MAIN FORM

These Expenses are for: ___ My Spouse ___ My Dependents/Children

Medical/Dental Expenses (attach copies of bills and proof of payment)

Receipt Number	Date DD/MM/YYYY	Illness/Injury (Reason for visit)	Doctor/Hospital	Total Bill Amount	Amount I/We Paid

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YEAR OF MEDICAL EXPENSES MUST MATCH YEAR OF UPDATED FINANCIAL INFORMATION ON MAIN FORM

Medical/Dental Expenses (attach copies of bills and proof of payment)

Receipt Number	Date DD/MM/YYYY	Illness/Injury (Reason for visit)	Doctor/Hospital	Total Bill Amount	Amount I/We Paid

TOTAL PAID:

Student & Spouse Certification:

I affirm that:

- All the information provided in this request is true and accurate to the best of my knowledge.
- The penalty for giving false information may include repaying any funds received.
- Turning in this form does not guarantee the request will be approved.
- Any decision based on this request cannot be appealed to the Department of Education.

Student (Required): _____ _____ ___/___/_____

Spouse (Required): _____ _____ ___/___/_____

Print Name **Signature** **Date**