Request for Forbearance/Hardship/Unemployment Deferment
SECTIONS 1, 2, AND 3 MUST BE COMPLETED IN FULL

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:
CUNY
C/O E.C.S.I.
PO BOX 15510
PITTSBURGH PA 15244

Email Address

Account Number:

LENDING INSTITUTION: F5-

Section 1 Applicable Benefits – Must be completed in full

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.

☐ **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 sections 2 and 3)**
(B)____ I am unable to make scheduled payments due to 'Poor Health' (temporarily – totally disabled). **(Complete sections 2 and 4)**
(C)____ Caring for a **dependent** who is disabled. **(Complete sections 2 and 4)**
(D) 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)

☐ **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 sections 2 and 3)**

☐ **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. **(Supporting documentation is required and "full completion of section 3")**
(B)____ I am receiving payment under Federal or State Public Assistance. (AFDC, Supplemental Security income, Food Stamps, or State Public Assistance). **("completion of sections 2 and 3 is required")**
(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 sections 2 and 3)**

☐ **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 duty registered with this employment agency.

Agency Name_____ Address_____

City_____ State_____ Zip_____ Phone number_____

Section 2 Borrower Certification – Must be completed in full

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 – Must be completed in full

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
_____	$_____	$_____
_____	$_____	$_____
_____	$_____	$_____
_____	$_____	$_____
_____	$_____	$_____
_____	$_____	$_____
Total	$_____	$_____

***PLEASE FURNISH CHECK STUB** ****PLEASE FURNISH EVIDENCE**

Section 4 Statement of Disability (Completed by Physician)

Patient's Name:_____

Relationship to Borrower:_____

Date when symptoms first appeared:_____

Date accident occurred:_____

Subjective symptoms:_____

Objective Symptoms :_____

Diagnosis :_____

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

	Any Occupation		Regular Occupation	
Is patient 'NOW' totally disabled for	YES_____	NO_____	YES_____	NO_____
If no, when is or was the 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_____

Physician Name_____ Physician License Number_____

Address_____

City_____ State_____ Zip_____

Phone Number_____ Fax number_____ Date_____

Attending Physician Signature_____