

**AES / GRANTS SPECIAL PROGRAMS
FORBEARANCE REQUEST**



Borrower Name _____ Account Number: _____

Address: _____ City _____ State _____ Zip Code _____

Telephone Number(____) _____ - _____ Alternate Telephone Number(____) _____ - _____

Employer Name _____ Telephone Number (____) _____ - _____ Years Employed _____

Address _____ City _____ State _____ Zip Code _____

Please select one of the following:

- Temporary Financial Hardship - Complete Section B
- Medical Financial Hardship - Complete Section A and B

Section A - Physician's Certification - must be completed for a Medical Financial Hardship Forbearance

Instructions: Complete and sign this form to certify that the disabled person is either temporarily or permanently disabled. Check the appropriate category and complete all requested information. If Permanent Disability is checked, please specify the nature, duration and severity of the borrower's present and future impairments. Attach additional pages if necessary.

____ Temporary ____ Permanent

The borrower became unable to work or to attend school on ____/____/____ and the disabling condition is expected to continue through ____/____/____ or continue indefinitely /result in death.

>When did the disabled person's illness or injury start? _____

>Diagnosis of disabled person's present medical condition: _____

>Borrower is ____ ambulatory ____ bed confined ____ house confined ____ other

>Prognosis - Is the condition static? ____ Yes ____ No - If no, what optimum improvement can be expected?

I certify that I am a doctor of medicine or osteopathy and legally authorized to practice and that in my best professional judgement, the disabled person named above is unable to work and earn money because of a medically determinable impairment.

Physician's Signature/Date _____ Physician's Name _____

Address _____ City _____ State _____ Zip Code _____

I certify that I am unable to make payments according to the present terms of my loan. The acceptance of this forbearance may result in my having to make increased payments as my repayment period will not be extended. My monthly payments will be calculated at the end of the forbearance based on the principal balance plus outstanding accrued interest at that time. I understand that I am responsible for keeping my loan current until the forbearance is applied and that negative credit reporting will not be removed even if the forbearance is applied retroactively.

Borrower Signature _____ Date _____

Section B - Financial Data - Must be completed for a Medical Hardship Forbearance or Temporary Hardship Forbearance

Part 1 - Average Monthly Revenues

<u>Type of Income</u>	<u>Amount</u>
Net Employment Income	\$ _____
Net Self-Employment	\$ _____
Investments: interest, dividends rental income, etc	\$ _____
Non-Taxable Income	\$ _____
Other: _____	\$ _____
<i>Total Part 1</i>	\$ _____

Part 3 - Assets

Cash on Hand	\$ _____
Checking account(s): Name of Financial Institution: _____	\$ _____
_____	\$ _____
Savings account(s): Name of Financial Institution: _____	\$ _____
_____	\$ _____
Other Interest account(s)	\$ _____
Stocks, bonds & securities	\$ _____
All Retirement accounts (IRA, 401K, KEOGH, others)	\$ _____
Debts owed to you	\$ _____
Vehicles: Type, Make, Model, Year _____	\$ _____
Resident real property & other real property owned	\$ _____
Other Assets	\$ _____
<i>Total Part 3</i>	\$ _____

Part 2 - Average Monthly Expenses

<u>Type of Expenses</u>	<u>Amount</u>
Rent/Mortgage	\$ _____
Homeowner/Condo Fees	\$ _____
Utilities	\$ _____
Food	\$ _____
Medical/Dental (non-reimbursable)	\$ _____
Household Expenses	\$ _____
Clothing	\$ _____
Insurance Premiums	\$ _____
Automobile Loan Payments	\$ _____
Student Loan Payments: Creditor Name (must be included) _____	\$ _____
_____	\$ _____
_____	\$ _____
Credit Card Payments: Creditor Name: _____	\$ _____
_____	\$ _____
Transportation Expenses	\$ _____
Other Expenses	\$ _____
<i>Total Part 2</i>	\$ _____

Please return completed form to:
American Education Services
P.O. Box 2461
Harrisburg, PA 17105-2461