Trinity College of Nursing & Health Sciences
UnityPoint Health

Institutional Financial Aid Questionnaire 2014-15

Dependent Student

Complete ALL information on this questionnaire. Incomplete information will be returned to the student. All information on this form is being collected to award financial aid in an equitable manner consistent with federal and state regulations.

Students Information

Name: _____ Social Security # _____
Last First MI

Date of Birth: _____/_____/_____ Are You a U.S. Citizen? YES _____ NO _____

Are you an employee of Iowa Health
Systems or any of it's affiliates? YES ____ NO _____ Name of facility _____

Permanent Address:

Address: _____
_____
Home Phone: _____
Cell Phone: _____ Email Address: _____

Local Address (If this address is the same as above, write "SAME")

Address: _____
_____
Phone : _____ Cell Phone _____ Email _____

If your address changes, please notify the Student Services Office

Parent's Information (Please provide information about the parents/step parent listed on your FAFSA)

Education Information

Name _____
First Name Last Name
Address: _____
_____
Phone: _____ Driver's License # _____
Birthdate: _____ Social Security # _____
Marital Status at time of FAFSA completion: Married ____ Separated ____ Divorced ____
Widowed ____ Single ____

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Education

Program you are pursuing: ASN ____ RAD ____ RESP ____ BSN-A ____ BSN-B ____ BSN-C ____

Have you ever attended a Trinity College of Nursing program before? YES ____ NO ____

List all post secondary institutions you have attended other than Trinity College of Nursing and the dates of attendance below and any Degrees you have received.

Name of Institution	From mo/yr	To mo/yr	Degree received

Family Information

List the people whom your parents will support between July 1, 2014 and Jun 30, 2015.
Include:

- **Yourself**
- **Your parents**
- **Your parents dependent children (if they will receive more than half of their support from your parents or if they would be required to provide parental information when applying for Federal Student Aid)**

Include other people only if they:

- Received more than half their support from your parents at the time you completed your application, **AND**
- Will continue to get this support between July 1, 2013 and Jun 30, 2014.
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Full Name	Age	Relationship	Attending College Y/N ?	COLLEGE (if half-time attendance or more)
		SELF	**Y**	**Trinity College**
		PARENT	**N/A**	

Employment Information

Have you ever been *approved* for a Work-Study position? YES ____ NO ____

Other *Expected* Financial Aid

SCHOLARSHIPS

Name _____

Summer $ _____Fall $_____Spring $_____

Name _____

Summer$ _____Fall $_____Spring $_____

VETERANS BENEFITS

Type_____

Special Circumstances

If you believe there are unusual circumstances that are out of your control (eg, loss of job) and should be considered in evaluating your eligibility for Financial Aid, please briefly describe your circumstances below and attach a letter and any documentation that supports your request. Please note, your letter should describe the situation and also how it is affecting you financially.

_____

_____

Certification

FINANCIAL AID INFORMATION RELEASE

The information on this questionnaire is true and complete to the best of my knowledge. I understand my information is confidential. I would like to give Trinity College of Nursing & Health Sciences permission to release my financial aid/billing to the following:

_____
Name(s) and relationship

_____
Student Signature Date
(Your typed name constitutes a signature to this document)