Trinity College of Nursing & Health Sciences
UnityPoint Health

Institutional Financial Aid Questionnaire
2025-2026

Independent 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.

Student Information

Name: _____ Social Security # _____
Last First MI

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

Are you an employee of Unity Point Systems or any of its affiliates? YES ____ NO _____

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.

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Housing Plans

Do you intend on living at home with your parents? YES ____ NO ____

Do you intend on living off campus with or without roommates? YES ____ NO ____

Education

Program you are pursuing: _____

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

Other Expected Financial Aid Including Scholarships

$_____ Date receiving _____

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:

_____
Release Information to: Name(s) and relationship

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

Revised 02/24/2025