SAINT FRANCIS MEDICAL CENTER COLLEGE OF NURSING

2026 – 2027 INSTITUTIONAL APPLICATION FOR FINANCIAL ASSISTANCE

PLEASE PRINT ALL INFORMATION IN INK

_____ _____ (_____) _____

Applicant's Name Social Security Number Phone

_____ _____ _____ _____

Mailing Address City/Town State Zip

_____

E-mail Address Marital Status: ☐ Single ☐ Married ☐ Widowed/Divorced ☐ Separated

_____ If married,_____

Date of Birth Spouse's Name

_____ _____ _____

Driver's License Number State of Issue Expiration Date

Are you/spouse/parent a veteran of the US Armed Forces? ☐ Yes ☐ No

If yes, will you be using VA education benefits at Saint Francis Medical Center College of Nursing? ☐ Yes ☐ No

Will you graduate from Saint Francis College of Nursing in the 2026/2027 school year? _____
If yes, give date (mm/yy) _____

Are you pursuing an undergraduate or graduate level degree at Saint Francis Medical Center College of Nursing?

☐ Yes ☐ No

If yes what program? ☐ BSN ☐ RN to BSN ☐ LPN to BSN ☐ MSN ☐ RN-MSN ☐ PGC ☐ DNP

☐ BSN to DNP ☐ DNP Post Master's DNP ☐ Accelerated BSN ☐ Other _____

(Post Graduate Certificate - Nurse Educator program does not qualify for federal financial assistance).

Do you currently have or will you have a bachelor's degree by July 1, 2026? ☐ Yes ☐ No

If you are an **undergraduate student**, do you currently have **pre-nursing courses** completed? (Please check one)

☐ Yes – Completed on _____ while in attendance at _____

Date College/University

☐ No - _____ _____

Anticipated Date of Completion College/University

Please select one:

Housing Plans: ☐ On Campus (Dorm) ☐ Parent's House ☐ Own Home/Apartment

SCHOLARSHIP / AGENCY INFORMATION

Do you authorize Saint Francis Medical Center College of Nursing to release application materials (including student status, name and address, grade point average, and financial data) to scholarship donor(s)/selection committee(s) or agencies for consideration or updating purposes in the 2026 – 2027 academic year?

☐ YES ☐ NO If no, the student will be responsible to submit all necessary information to their scholarship or agency unless prior written permission is given.

If you have been awarded 2026 – 2027 assistance from private scholarships offered by community, religious or civic groups, the Student Finance Office requires a copy of your notification letter.

SPECIAL CIRCUMSTANCES

If you would like the college to review any special family circumstances or changes in your financial situation not reported on the Free Application for Federal Student Aid (FAFSA), please attach a separate signed and dated sheet.

CERTIFICATION BY APPLICANT

- I certify the information in this application is complete and accurate to the best of my knowledge. I understand that if I fail to provide accurate information, all or part of my financial aid may be withdrawn, and I may be required to repay all or part of the money I have received.
- I will report to the Student Finance Office any additional financial aid received, any changes in my financial status, dependency status, or appropriate information if I become convicted of possession or sale of a controlled substance.
- I understand that aid granted me may be modified or suspended, dependent upon rules, regulations, policies and appropriations applicable to aid programs.
- I affirm that I will use any funds I receive under Title IV programs (Federal Pell Grant, ISAC-MAP, and Direct Education Loan Programs) solely for expenses related to attendance at Saint Francis Medical Center College of Nursing.
- I understand that I am responsible for repaying any funds I receive which cannot reasonably be attributed to meeting my educational expenses at Saint Francis Medical Center College of Nursing. I further understand that the amount of any repayment is based on regulations published by the Department of Education.
- I understand that financial aid funds I am awarded will be applied first to outstanding bills I owe to Saint Francis Medical Center College of Nursing.
- I understand that I will not be eligible to receive State and/or Federal funding until prerequisite courses are complete and recorded in the Registrar's office.

_____ _____

Student's Signature in Ink Date

Authorization Form - Disbursement of Title IV Financial Aid

I authorize Saint Francis Medical Center College of Nursing to apply Title IV HEA program funds to pay for all charges, including activity fee, full semester dorm room fee, study room fee, course fee, technology fee, testing fee, graduation fee, late charges, and additional fees applied to the student's account incurred at Saint Francis Medical Center College of Nursing.

If I do not give my permission to deduct all charges incurred, I understand that the Student Finance Office will deduct only my tuition, fees and contractual charges and I will be responsible to pay all other charges personally.

The student's written authorization remains in effect for the entire academic year. The student or parent may modify or cancel at any time. Any modification or cancellation must be submitted in writing to the College of Nursing Student Finance Office. The school may use Title IV funds to pay for previously authorized charges that were incurred before the modification or cancellation request is received.

_____ _____ _____

Student's Signature Social Security Number Date