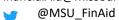
Phone: (417) 836-5262 Phone: (800) 283-4243 Fax: (417) 836-8392

FinancialAid@MissouriState.edu





Office of Student Financial Aid Carrington Hall, Room 101 901 S. National Ave. Springfield, MO 65897

www.MissouriState.edu/FinancialAid

SUMMER 2025 Special Programs Request for Budget Increase for Additional Expenses				
Last	First	(required)		
Brain Start and Cha dates may ve	ay. Check the appropriate box and atta	ion documentation.		
	ary. Check the appropriate box and atta	ester and between May 26 – August 1, 2025. Inch documentation.		
Deadline for processing: ple	ase complete ALL required steps and subm <mark>July 11, 2025</mark>	it form to the fax/email/address above by:		
	<b>-</b>			
dicate Academic Program: (DNA	AP, DSS, OT, PA or PT):			
		Documentation Poquired		

Circumstance	Documentation Required (print your BearPass # on each page)	
Additional background check/drug screening/immunizations – required for clinical rotation	Copy of paid receipt in student's name	
Childcare Expenses – for periods of time during class time, study time, field work, research, internships, or commuting time	Completed & signed Childcare Expense Worksheet Summer 2024	
Computer Purchase — one-time purchase for current graduate program	Copy of paid receipt in student's name	
Car Repair Cost - does not apply to the purchase of a new car, annual maintenance, or tires	Copy of paid receipt in student's name	
<b>Health Insurance Premium</b> (student only) for total cost greater than \$4,194/year	Copy of paid receipt in student's name	

TRAVEL DUE TO CLINICAL ROTATION/INTERNSHIP - exp required for current degree program and occur 15 miles from student's current address	<ul><li>Documentation by your program department</li><li>Required for Course #</li></ul>	
		dress (name of clinic or hospital, full address, (attach letter of approval)
Start date of clinical rotation:	End date of clinical rotation:	
Schedule of rotation (list days and hours—attach separate shee	t or agreement)	
number of round trips to site during summe	er semester	
	)R	
HOUSING DURING CLINICAL ROTATION [not applicable or OT students] (full address, city, state & zip for clinical site and number of months X \$ monthly	housing):  • F • (  (  r • C	Documentation by your program department Required for Course # Copy of current housing arrangement mortgage statement or lease) in student's name (primary residence) Copy of lodging agreement (rental agreement, hotel bill) in student's name secondary)
gning below,		
I acknowledge that I have attached all supporting document to the best of my knowledge. I understand that I may be asked for additional information I understand that if this form is incomplete or lacks the reculunderstand this request is for one semester and I will need understand that submitting this form does not guarantee	n or my request quired documented to reapply eac	can be partially or completely denied. tation, no action will be taken. ch semester that my situation warrants.