OFFICE OF STUDENT FINANCIAL ASSISTANCE
APPEAL FORM

TO: FINANCIAL AID APPEAL COMMITTEE
OFFICE OF STUDENT FINANCIAL ASSISTANCE

FROM: ______________________________
NAME OF STUDENT

ADDRESS: ______________________________
NUMBER STREET

____
CITY STATE ZIP CODE

PHONE #: ______________________________

SOCIAL SECURITY #: ______________________________

PLEASE INDICATE THE SEMESTER AND YEAR THAT THIS APPEAL IS FOR:

______________ ______________
SEMESTER YEAR

HAVE YOU BEEN GRANTED A FINANCIAL AID APPEAL PREVIOUSLY? ☐ YES ☐ NO
IF YES, WHAT SEMESTER AND YEAR:

______________ ______________
SEMESTER YEAR

PLEASE INDICATE WHAT CAMPUS YOU ATTEND:

☐ CHARITY SCHOOL OF NURSING ☐ WESTBANK CAMPUS
☐ CITY PARK CAMPUS ☐ COMMUNITY CAMPUS

I hereby request that my case be reviewed for possible reinstatement of my financial aid. I understand that only exceptional cases which can be documented will be approved. I have attached such documentation. (i.e., doctor's statements, copies of death certificates, hospital bills, etc.)

In addition to your own appeal, you may wish to ask an appropriate Delgado official who is familiar with your situation to support your appeal. (See instructions on the Appeal Support Form).

Please indicate:

☐ I will ask ______________ (Name of Supporter) to submit the Appeal Support Form. Please note, if you check this box, your file will not be process until both the Appeal Support Form, and your Student Appeal Form, is received in our Office.

☐ I will not ask that the Appeal Support Form be submitted.

(OVER)

Describe in detail the mitigating circumstances and how they impacted your performance.

Describe in detail what steps you have taken to attempt to remove the circumstances and whether the circumstances have, in fact, been removed.

DATE

STUDENT SIGNATURE

NOTE: ALL APPEALS MUST BE SUBMITTED TO THE OFFICE OF STUDENT FINANCIAL ASSISTANCE WITHIN THIRTY (30) DAYS AFTER CLASSES BEGIN WITH RESPECT TO A FALL OR SPRING SEMESTER, AND WITHIN TEN (10) DAYS AFTER CLASSES BEGIN WITH RESPECT TO THE SUMMER SESSION.