

UNIVERSITY OF ROCHESTER SCHOOL OF MEDICINE & DENTISTRY
FINANCIAL AID APPLICATION FOR 2025-2026: M.P.H. & M.S. Students

Name _____ SS# _____
Last First MI

Permanent Address _____

School Address _____

Home Telephone _____ School Telephone _____ Department _____ Box # _____

E-mail Address _____

ACADEMIC INFORMATION

Expected Graduation Date (mm/dd/yy) _____ Degree Program _____

Unless you indicate otherwise, MS and M.P.H. candidates are assumed to be enrolled for 9 months. Please indicate how many months you will be enrolled for the 2024-2025 academic period:

☐ 12 months ☐ 9 months ☐ Other (specify) _____

Enrollment Status - Number of credit hours: Fall 25 _____ Spring 26 _____ Summer 26 _____

FINANCIAL INFORMATION

Indicate below the assistance which you anticipate receiving for the 2025-2026 academic year. This amount will be included as resource in determining your need for additional financial assistance.

1. Tuition Support from your Dept.: ☐ Full ☐ Partial ☐ None If partial, indicate amount/percentage: \$ _____

2. Health Fee Coverage by your department: ☐ Full ☐ Partial ☐ None

University Health Insurance (Check one):

☐ I plan on waiving the Optional University Health Insurance because I am covered by other insurance.

***Note:** You will need to formally waive the Optional University Health Insurance on University Health Service's website.*

☐ I plan on accepting the Optional University Health Insurance for the 2025-2026 Academic Year.

Indicate below the assistance that you are applying for:

☐ Federal Stafford Loans ☐ Federal Work-study ☐ Other

APPLICATION DOCUMENTS REQUIRED

☐ Submit a University of Rochester Financial Aid Application.

☐ Submit a FAFSA (Free Application for Federal Student Aid). Approximate submission date: _____

FEDERAL STAFFORD LOANS

First time SMD borrowers eligible for Federal Stafford loans will receive instructions on signing a promissory note and completing student loan entrance counseling from the Financial Aid Office.

To the best of my knowledge, I affirm that the information submitted on this form and all other financial aid forms is accurate, true, and complete. Furthermore, I agree to notify the Financial Aid Office of the School of Medicine and Dentistry of any change affecting my/our financial status during the 2024-2025 academic year.

Signature: _____ **Date:** _____

Submit to: Financial Aid Office, University of Rochester School of Medicine & Dentistry
601 Elmwood Avenue - Box 601, Rochester, NY 14642-0001