



## Institutional Financial Aid Questionnaire 2024-2025

### Dependent 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.

### **Students 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

### **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 \_\_\_\_



**Parent’s Information (Please provide information about the parents/step parent listed on your FAFSA)**

**Education Information**

Name \_\_\_\_\_  
 First Name Last Name

Address: \_\_\_\_\_  
 \_\_\_\_\_

Phone: \_\_\_\_\_ Driver’s License # *(if requested by FA rep)* \_\_\_\_\_

Birthdate: \_\_\_\_\_ Social Security # \_\_\_\_\_

Marital Status at time of FAFSA completion: Married \_\_\_\_ Separated \_\_\_\_ Divorced \_\_\_\_  
 Widowed \_\_\_\_ Single \_\_\_\_

**Education**

Program you are pursuing: RAD \_\_\_\_ BSN-A \_\_\_\_ BSN-B \_\_\_\_  
 BSN-C \_\_\_\_ BSHS \_\_\_\_ MSN \_\_\_\_ MLS \_\_\_\_

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

List all post-secondary institutions you have attended other than Trinity College of Nursing and the dates of attendance below and any Degrees you have received.

Name of Institution	From mo/yr	To mo/yr	Degree received



**Family Information**

List the people whom your parents supported between July 1, 2023 and June 30, 2024. Include:

- Yourself
- Your parents
- Your parents' dependent children (if they will receive more than half of their support from your parents or if they would be required to provide parental information when applying for Federal Student Aid)

Include other people only if they:

- Received more than half their support from your parents at the time you completed your application, **AND**
- Will continue to get this support between July 1, 2024 and June 30, 2025.

Full Name	Age	Relationship
		<b>SELF</b>
		<b>PARENT</b>

**Other *Expected* Financial Aid**

**SCHOLARSHIPS**

Name \_\_\_\_\_

Summer \$ \_\_\_\_\_ Fall \$ \_\_\_\_\_ Spring \$ \_\_\_\_\_

Name \_\_\_\_\_

Summer\$ \_\_\_\_\_ Fall \$ \_\_\_\_\_ Spring \$ \_\_\_\_\_

**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.

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## **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:

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Release Information to: name(s) and relationship

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

Date