College of Medicine
Phoenix

COLLEGE OF MEDICINE PHOENIX
475 N. 5th Street, Phoenix, AZ 85004
PHONE: 602.827.3669
Email: COMPHX-Financialaid@arizona.edu

COST OF ATTENDANCE (BUDGET) RE-EVALUATION - ACADEMIC YEAR 2023-2024

*Please contact the College of Medicine Financial Aid Office for guidance.

This form has been designed to allow you to provide information regarding your cost of attendance (COA) during the academic year. The items listed below are included in the standard academic year budget used at the University of Arizona. If the budget reported on your award notification does not appear to adequately meet your expenses, please document your actual expenses below.

Any changes to your financial aid are considered on a case-by-case basis, are not guaranteed to be approved, and contingent on funding. Keep in mind that the majority of COA re-evaluations typically increase loan eligibility. Please also be aware that the COA is to support the student and a student's educational expenses and does not take into consideration expenses for a student's spouse and/or dependents. Also, we cannot increase your COA due to credit card payments or other consumer debt.

Please type or write in dark ink. DO NOT use pencil.

LAST NAME:	FIRST:	MI:	STUDENT ID #:
ADDRESS:		ZIP:	
PHONE:		E-MAIL:	
☐ 1st Year Medical	☐ 2nd Year Medical	☐ 3rd Year Medical	☐ 4th Year Medical

COSTS:	DESCRIPTION: MONTHLY (Include student expenses only)		
Rent/Mortgage	Report expenses if your share of rent/mortgage exceeds the budgeted $1,040 per month **(documentation required)** - do not include costs covered roommate(s)	PER MONTH	$
Utilities	Report expenses if your share of electricity, gas, water, internet, & trash pick-up exceeds the budgeted $310 per month **(documentation required)**	PER MONTH	$
Food:	Report expenses if your monthly share exceeds the budgeted $620 per month **(documentation may be requested)**	PER MONTH	$
Do you have a spouse who is receiving financial aid at any institution? ☐ Yes ☐ No			
OTHER COSTS:	**DESCRIPTION: YEARLY (Include student expenses only)** ***All items below require documentation such as photocopies of receipts and/or estimates.**		**Academic Year Amounts (MS1 through MS 3 -12 months & MS 4- 11 months)**
Medical Insurance:	If other than UA student insurance; student only - not family	PER ACAD. YEAR	$
Books/Supplies:	Give total for the academic year and then provide list of books/supplies with costs and purpose	PER ACAD. YEAR	$
Computer:	Include software or hardware upgrades needed for coursework	PER ACAD. YEAR	$
Miscellaneous:	Personal Expenses: Itemize your monthly miscellaneous expenses for cell phone, clothing, laundry, & personal care (prescriptions, toiletries, personal grooming etc.) only if it exceeds $4,200 for MS1-3 or $3,850 for MS4 - $350 monthly	PER ACAD. YEAR	$
	Medical/Dental Expenses: May include medical, dental, & optical expenses NOT covered by insurance (do not include insurance premiums)		$

*Transportation and/or childcare costs can be submitted using the next page(s) as needed.

I certify that the information on this cost of attendance reevaluation is accurate to the best of my knowledge.

Student Signature: ____ **Date:**____________________

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TRANSPORTATION EXPENSES - Academic Year 2023-2024

*Please contact the College of Medicine Financial Aid Office for guidance.

Please type or write in dark ink. DO NOT use pencil.

LAST NAME:	FIRST:	MI:	STUDENT ID #:
ADDRESS:		ZIP:	
PHONE:		E-MAIL:	
☐ 1st Year Medical	☐ 2nd Year Medical	☐ 3rd Year Medical	☐ 4th Year Medical

You only need to complete and submit this page if you are requesting an increase for transportation related expenses. You should only do this if your costs exceed $320 per month. Please do not include car payments as they cannot be considered.

ADDENDUM: **Transportation Expenses for Academic Year (Supporting documentation may be required)**

(College of Medicine Year 1 = 12 months; Year 2 = 12 months; Year 3 = 12 months; Year 4 = 11 months)

$ ________________ Registration of vehicle (one year)

$ ________________ Vehicle Insurance ($ _________ per month; #months ____)

$ ________________ Parking permit (permit type: __________)

$ ________________ Fuel (Average fuel $ __________ per month; #months: ____)

$ ________________ Oil changes per academic year (cost $ _________; Quantity: _____)

Car service or repairs (must include receipt). Vehicle repairs will be considered on student's vehicle only and must occur during current enrollment period. Repairs exceeding $3,000 may require additional documentation.

$ ________________ Date: ___________ Nature of Repair: ____

$ ________________ Date: ___________ Nature of Repair: ____

$ ________________ Date: ___________ Nature of Repair: ____

$ ________________ Date: ___________ Nature of Repair: ____

$ ________________ **Total Yearly Transportation Expenses**

I certify that the information on this cost of attendance reevaluation is accurate to the best of my knowledge.

Student Signature: ____ Date:____________________

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CHILDCARE EXPENSES - Academic Year 2023-2024

*Please contact the College of Medicine Financial Aid Office for guidance.

Childcare may be added to your budget if incurred costs are to attend school.

To request additional financial aid for child care costs:

1. Section A of this form to be completed by the COM-P student.
2. Have your childcare provider complete Section B of this form.
3. Submit this form to the College of Medicine Phoenix Financial Aid Office. Attach a copy of your child care contract or agreement (if there is one).

Please type or write in dark ink. DO NOT use pencil.

SECTION A (To be completed by student)			
LAST NAME:	FIRST:	MI:	STUDENT ID #:
ADDRESS:		ZIP:	
PHONE:	E-MAIL:		

Name(s) of Dependents Requiring Child Care	Age and Birthdate (include year)

Do you receive child care subsidies from other sources: ☐ Yes ☐ No
If yes, indicate the source and the amount received per month for all children listed in Section A.

I certify that the above information is true and correct, and I authorize UA College of Medicine Phoenix to obtain information about child care subsidies that I may be receiving.

Student's Signature: **Date:**

SECTION B (Completed by child care provider)	
NAME:	
RELATED TO STUDENT:	If yes, describe:
ADDRESS:	
TELEPHONE:	

Names of Student's Dependents for Whom You Provide Care	Fee/Per: Day, hour, month	Number of Days Each Month	Total Amount Each Month	Beginning and End Dates of Care

I certify that the above information is true and correct.

Childcare Provider's Signature: **Date:**