TULANE UNIVERSITY

Tulane University Financial Aid

2026–2027 Request for Reconsideration of Federal Financial Aid

Important: This form is only for federal financial aid reconsideration. Submission does not guarantee a change in federal aid eligibility. Submission of this form will not result in a reconsideration of institutional aid.

Student Information

Student Name:	
Tulane ID:	

Before Submitting This Request

Please confirm all items below before submitting this form. Requests may not be reviewed until all required items are received.

☐ The 2026–2027 FAFSA has been submitted, processed, and received in the student's Gibson Portal.

☐ All outstanding required documents listed on the Gibson To Do List have been submitted.

☐ Signed 2024 federal tax return copies have been submitted, if requested, to support the base prior-prior year information reported on the FAFSA.

Request Type

Select the type of federal reconsideration request being submitted:

☐ Income Reconsideration - significant reduction in 2025 income compared with 2024 income

☐ Medical Expense Reconsideration - out-of-pocket medical expenses paid by the family

☐ Both Income and Medical Expense Reconsideration

Section A: Income Reconsideration

Complete this section only if requesting reconsideration due to a significant reduction in income.

☐ Signed 2024 federal tax return copies have been submitted.

☐ Signed 2025 federal tax return copies have been submitted for review.

☐ Other applicable income documentation has been submitted for review.

☐ A brief explanation of the income reduction is provided below.

Brief explanation of income change/reduction:

_____

_____

_____

_____

Section B: Medical Expense Reconsideration

Complete this section only if requesting reconsideration of substantial out-of-pocket medical expenses.

☐ Documentation/receipts/statements for out-of-pocket medical expenses submitted.

☐ An attached summary document clearly outlines the figures being requested for consideration.

☐ Only expenses paid out of pocket by the family are included. Insurance-covered or reimbursed amounts are not included.

Expense Category	Amount Paid Out of Pocket	Date Paid	Documentation Attached?

Total out-of-pocket medical expenses requested for consideration: $ _____

Certification and Signature

By signing below, I certify that the information submitted with this request is true and complete to the best of my knowledge. I understand that submitting this request does not guarantee an adjustment to federal financial aid eligibility and that additional documentation may be requested.

Student Signature: _____ **Date:** _____

Parent/Guardian Signature: _____ **Date:** _____