MADISON COLLEGE FINANCIAL AID
SAP Medical Documentation

STUDENT INFORMATION - Complete this section and give it to your healthcare provider to complete the remaining section.

Name _____ Student ID or Social Security Number _____

Are you the? ☐ Patient ☐ Spouse ☐ Parent ☐ Other _____

By signing, I authorize my healthcare provider to release my protected health information requested below to the Madison College Financial Aid Office, 1701 Wright Street, Madison, WI 53704.

Patient's Name _____

Patient's or Guardian's Signature _____ **Date** _____

HEALTHCARE PROVIDER INFORMATION - To be filled out by healthcare provider

Your patient (or patient's family member) is a student at Madison College who is applying for financial aid reinstatement. Their appeal indicates that there was a medical emergency outside of their control that caused them to be unsuccessful.

INSTRUCTIONS - If the form is incomplete or illegible, the appeal may be denied for insufficient information. For assistance, contact the Financial Aid Office at (608)246-6170. If more space is needed, please attach a separate letter on letterhead with the student's name and student ID. This form must be sent directly from the healthcare professional to the Financial Aid Office.

Date of initial appointment: _____ Date of initial diagnosis: _____

Dates of follow-up appointments: _____

If the answers to the following questions are yes, please give the dates applicable.

Was the patient admitted into the hospital? From: _____ To: _____

Was the patient (if student) advised not to work? From: _____ To: _____

Was the patient (if student) advised not to attend school? From: _____ To: _____

If no, did the patient's medical condition reasonably prevent the student from attending classes and/or completing coursework for an extended period of time? ☐ Yes ☐ No

Is the student now able to return to school? ☐ Yes ☐ No

What was the diagnosis? _____

What impact did this diagnosis have on the **student** and their ability to carry out their job or school responsibilities? For pre-existing conditions, please describe the changes in the situation that occurred that affected job or school responsibilities.

_____

_____

_____

_____

Was the patient following all recommended courses of treatment(s)? ☐ Yes ☐ No If no, please describe below:

Comments, restrictions, or description of treatments not followed (if applicable)

_____

_____

_____

HEALTHCARE PROVIDER'S SIGNATURE & AGREEMENT

By signing, I agree that the information provided above and any attachments are true and accurate.

Signature _____ **Date** _____

Name _____ Title _____

Organization _____ Phone Number _____

HEALTHCARE PROVIDER SUBMISSION INSTRUCTIONS - Please print, sign and send completed form to the Madison College Financial Aid Office by fax at (608) 243-4245.