SUPPLEMENTAL APPLICATION: 2016-2017
UC Davis Health System Financial Aid

This form must be completed in its entirety. Return via (choose one): Fax: (916) 734-4116 Email: hs-financialaid@ucdavis.edu Mail or drop-off: Financial Aid Office, UC Davis Health System, 4610 X Street, Sacramento CA 95817

1. Name: ____________________________________ UCD Student ID #:________________________________

2. Residence/local address: Mailing address (if different):

Telephone: ____________________________________ Email: ____________________________________

3. Will you live with parents, guardians, or other relatives and/or in a residence owned by them during the school year? NO YES, details:______________________________ If YES, rent paid per month: $_________

4. To which degree program/curriculum were you officially accepted?

SCHOOL OF MEDICINE (circle all that apply): M.D. M.D./ACE-PC M.D./Ph.D. TEACH-M.S. Rural-PRIME San Joaquin Valley-PRIME

SCHOOL OF NURSING (circle one): * Physician Assistant Studies (M.H.S.)

Rural-PRIME San Joaquin Valley-PRIME

OTHER PROGRAMS:

Health Informatics (M.S.) Public Health (M.P.H.) * Leadership: Ph.D. or M.S. * Nurse Practitioner (M.S.) * Nursing Entry Program (M.S.)

5. Expected graduation date: 2017 2018 2019 2020 Other: ________________

6. Will you enroll in school-sponsored health insurance? YES NO

If NO, what is the source of your coverage (circle one)? PARENT(S) SPOUSE/PARTNER OTHER: ________________

7. Estimated 2016-2017 school-year income (DO NOT LEAVE ANY BLANKS) July 2016 through June 2017

<table>
<thead>
<tr>
<th>Description</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>a) Gross income (before taxes) earned from work</td>
<td>$</td>
</tr>
<tr>
<td>b) Spouse’s gross income (before taxes) earned from work</td>
<td>$</td>
</tr>
<tr>
<td>c) Other taxable income (e.g., interest, dividends)</td>
<td>$</td>
</tr>
<tr>
<td>d) Other financial help or expenses paid on your behalf</td>
<td>$</td>
</tr>
<tr>
<td>List source(s):</td>
<td></td>
</tr>
<tr>
<td>e) Outside (non-UCD) aid (e.g., scholarships, private loans)</td>
<td>$</td>
</tr>
<tr>
<td>List source(s):</td>
<td></td>
</tr>
<tr>
<td>f) Nontaxable income (TANF, child support, etc.)</td>
<td>$</td>
</tr>
<tr>
<td>List source(s):</td>
<td></td>
</tr>
</tbody>
</table>
8. a) Are you an Armed Forces veteran?  YES      NO  
   If YES, do you plan to use veteran benefits?  YES      NO  TYPE____________ ESTIMATED $___________  
b) Are you Active Duty/ROTC/Reservist?   YES    NO  
   If YES, will you use DOD tuition assistance?  YES     NO       $______________  

9. Have you ever attended a health profession program at another institution (e.g., nursing, dental, chiropractic, veterinary medicine)?  _____YES    _____NO  If YES, complete next section.  
   Institution name: ________________________________________  
   Received aid?    _____YES    _____NO  
   Address:  _______________________________________________________________________________  
   Attended from: _______________ (month/year)     to   _______________ (month/year)  

10. Indicate your level of credit card debt:  _____$0-$2,500    _____$2,501-$5,000    _____$5,001-$7,500  _____over $7,500  
   (For informational purposes only (your answer will not affect your financial aid eligibility).  Note, however, that credit 
worthiness is needed to qualify for the federal Graduate PLUS Direct Loan and private loans.)  

MEDICAL STUDENTS ONLY – Complete This Section  

➢ To qualify for special federal funding: Were you claimed as a dependent on someone else’s tax return in:  
   2015  No / Yes (_____________)  2014  No / Yes (_____________)  2013  No / Yes (_____________)  

➢ Do you intend to practice in:  
   -A medically-underserved community*?    YES    NO  
   -Primary care*?                                      YES    NO  
   -A rural* community?                                 YES    NO  

➢ Are you from a rural background?                  YES    NO  

➢ Have you received training in any pipeline programs*?    YES    NO    NOT SURE  
   If yes, please name the program and dates you received training:  
   ___________________________________________________________________________________

➢ M.D. students entering Years 3-4: A subsidized low-interest federal loan (Primary Care Loan) is available for 
students going into primary care (e.g., general pediatrics, general internal medicine, or family medicine).  Are you 
100% certain you will enter a primary care residency and practice primary care for no less than 10 years after 
graduation, including residency years?  Do you wish to be considered for this loan?  _____YES     _____NO  

11. ALL STUDENTS: Provide information on all members of your (student) household* (include yourself):  

<table>
<thead>
<tr>
<th>Full name of family member</th>
<th>Age</th>
<th>Relationship to you</th>
<th>Will attend college at least ½ time in 2016-2017</th>
<th>Name of school or college in 2016-2017 school year</th>
<th>Grade level in 2016-2017</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>SELF</td>
<td>YES</td>
<td>UC DAVIS</td>
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</table>

*If additional household members, attach additional pages.  

12. Certification: My signature certifies that all of the information on this form is true and complete to the best of my knowledge.  I realize that information from this form will be used for the purpose of determining student aid eligibility. If asked by an authorized official, I agree to give proof of the information that I have given on this form.  I realize that this proof may include a copy of my federal income tax return (or foreign tax return if applicable), and may also include completing IRS Form 4506-T to obtain an official transcript of my federal income tax information.  I realize that if proof is not provided when requested, I may be denied aid.  

Student signature  

Date  

February 5, 2016
DEFINITIONS

Medically-Underserved * Primary Care * Rural * Pipeline Programs

Medically-Underserved Community
Medically-underserved communities are designated as having shortages of primary medical care, dental or mental health providers and may be geographic (a county or service area), demographic (low-income population) or institutional (comprehensive health center, federally-qualified health center of the other public facility). Medically-underserved communities are areas or populations designated as having: too few primary care providers, high infant mortality, high poverty and/or high elderly populations.

The term “Medically-Underserved Community” means an urban or rural area or population that:

(A) is eligible for designation under Section 332 of the PHS Act as a health professional shortage area (HPSA);

(B) is eligible to be served by a migrant health center under Section 329 [now 330(g)] of the PHS Act, a community health center under Section 330 of the PHS Act, a grantee under Section 330(h) of the PHS Act (relating to homeless individuals), or a grantee under Section 340A [now 330(i)] of the PHS Act (relating to residents of public housing);

(C) has a shortage of personal health services, as determined under criteria issued by the Secretary under Section 1861(aa)(2) of the Social Security Act (relating to rural health clinics); or

(D) is designated by a state governor (in consultation with the medical community) as a shortage area or medically-underserved community.

See:  http://hpsafind.hrsa.gov

General Primary Care Fields
Family Medicine, Internal Medicine, Pediatrics, combined Medicine/Pediatrics, Preventive Medicine, General Medicine

Practice activities include Occupational Medicine, Public Health, Public Policy Fellowship, Geriatrics, Adolescent Medicine, Sports Medicine.

Rural Area, Rural Background
Rural = population 2,500-49,999; not on the outskirts of a metropolitan area
Remote = population less than 2,500; an isolated community


Pipeline Programs
Pipeline programs include Area Health Education Centers (AHEC), Centers of Excellence (COE), Health Careers Opportunity Programs, Nursing Workforce Diversity