Alaska Commission on Postsecondary Education

P.O. Box 110505
Juneau, Alaska 99811-0505
Toll Free: (800) 441-2962 • TDD: (907) 465-3143
In Juneau: (907) 465-2962 • Fax: (907) 465-5316
acpe.alaska.gov

Application for Medical Deferment of Repayment

Instructions: Read and complete Section I in its entirety. Give the application to the medical authority for completion of Section II on Page 2 of this form. Return the completed form to this agency at the above address within 30 days, or before your loan(s) default, whichever occurs first. Retain a copy of this form for your records.

NOTE: Any person who knowingly makes a false statement or misrepresentation on this form has committed the crime of perjury.

I. Medical Deferment Conditions & Certification – To be completed by the borrower.

Medical Deferment Conditions:

1. Monthly payments due must be made until notification of deferment approval has been received by me.
2. My repayment schedule will be amended.
3. I have been evaluated by a licensed medical authority within the last three months.
4. It is my responsibility to obtain the necessary certification of disability before my deferment can be considered.
5. My disability must be certified by a medical authority who is licensed to practice and who is qualified to attest to the extent and the nature of my disability.
6. If I received my loan(s) before the 1996-97 school year, I must be 50% or more disabled and unable to work or attend school. If I received my loans during or after the 1996-97 school year, I must be totally disabled and unable to work or attend school to qualify.
7. My medical deferment will be granted for a maximum of six months and I must apply for renewal if the condition continues beyond that time.
8. If my disability is based on a condition that existed at the time the loan was received, the medical authority must certify that my condition has substantially deteriorated since then and I am currently unable to work or attend school with or without reasonable accommodation.
9. If I am currently making payments on a reduced payment schedule, my reduced payment agreement is void.
10. All requirements outlined in my Promissory Note are binding.
11. Loan(s) received for, or after, the 1996-97 school year accrue interest during deferment periods. This interest may be capitalized when payments resume.
12. There is a six-month grace period following medical deferment on loans received for school year 1994-95 or earlier. Interest is charged during the grace period on loans received for school year 1987-88 and after. The total indebtedness will increase when the deferment period ends. When payments resume, accrued unpaid interest must be satisfied before payments are applied to principle.
13. If approved, my deferment status will not begin more than 30 days prior to receipt of this completed form.
14. It is my responsibility to inform ACPE of any address or name changes that occur during the life of the loan and if, or when, I no longer qualify for this medical deferment.
15. When payments resume following this deferment, the minimum monthly payment on my account will be at least fifty dollars ($50.00) a month.
16. If this deferment request is denied, all past due amounts are payable immediately. If alternate financial arrangements are necessary, contact the ACPE at the address and phone numbers at the top of this form.

Name: ______________________ SSN or Account Reference Number: ______________

Address: ______________________ Home Phone: ______________

City, State, Zip: ______________________ Business Phone: ______________

Certification: By signing this form, I certify that I have read and understand the above facts relative to any request for medical deferment. I also certify that I am eligible for deferment of repayment, my account is not in default status, and that I understand and meet the conditions indicated on this form.

In addition, I authorize any physician, hospital, or other health service institution to provide the Alaska Commission on Postsecondary Education (ACPE) with the information they need to evaluate my request for deferment of loan payments.

Borrower Signature: ______________________ Date: ______________

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II. Medical Information - To be completed by a licensed medical authority. Physician's/medical office may be contacted.

- Please keep a copy of this release form in your patient's records -

1. Diagnosis & Treatment:

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2. History & Extent of Disability:

a. Date illness began or injury occurred: ____________

b. Date patient ceased employment or program of study because of disability: ____________

c. First date you evaluated this patient: ____________ Last date you evaluated this patient: ____________

d. Current disability rating: ☐ less than 50% ☐ 50% or more ☐ totally disabled

e. Is the condition permanent?: ☐ No ☐ Yes

f. Can the patient be rehabilitated?: ☐ No ☐ Yes

g. Will the patient be capable of resuming employment or program of study with or without reasonable accommodation?: ☐ No ☐ Yes If Yes, when? : ____________

h. Patient is: ☐ Ambulatory ☐ Bed Confined ☐ House Confined ☐ Hospital Confined

i. Progress: ☐ Recovered ☐ Improved ☐ Unimproved ☐ Retrogressed

3. Explain how the disability prevents the patient from resuming work, school, or vocational rehabilitation:

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Please attach any additional information relevant to document the patient's condition.

Name of medical authority: ____________________ Phone Number: ____________________

Address: ____________________ City, State, Zip: ____________________

Degree Information: ____________________ Licensing State: ________ License Number: ________

Signature of medical authority: ______________________________ Date: ____________