Alaska Commission on
Postsecondary Education

P.O. Box 110505
Juneau, Alaska 99811-0505
Toll Free: (800) 441-2962 • TTY: Dial 711 or 800-770-8973
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 (M.D., D.O., Surgeon, or Psychiatrist only) for completion of Section II on Page 2 of this form. Email the completed form to ACPE@alaska.gov, or fax or mail it to ACPE as soon as possible to avoid default. Please retain a copy of this form for your records. **Incomplete applications will not be processed.**

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.

In addition to the terms and conditions described in AS 14.43 and 20 AAC 15, I understand the following conditions must be met to qualify for this deferment:

1. This deferment request is for a short-term medical situation preventing me from making monthly payments.
2. Monthly payments are due under my current repayment schedule until I receive notification of deferment approval.
3. If I am currently making payments on a reduced payment schedule, my reduced payment agreement is void. I will need to reapply for a reduced payment when the deferment ends.
4. My disability must be certified by a licensed medical authority (M.D., D.O., Surgeon, or Psychiatrist only) qualified to attest to the extent and the nature of my disability, and who has evaluated me within the last three months. NOTE: a Physician's Assistant (PA-C) may certify my disability, only if there is a supervising physician, whose name, address, phone, license number, and degree information is provided on this form.
5. I am responsible for obtaining the necessary certification from my physician before ACPE can consider my deferment request.
6. If I received my loan(s) before the 1996-97 school year, I must be temporarily 50% or more disabled, and unable to work or attend school, to qualify for this deferment. If I received my loans during or after the 1996-97 school year, I must be temporarily totally disabled, and unable to work or attend school, to qualify.
7. If my disability is for a condition that existed when my loan was received, the medical authority must certify that my condition has substantially deteriorated since then, and that I am currently unable to work or attend school, with or without reasonable accommodation, on a temporary basis.
8. If I applied for a medical cancellation, and was denied under 20 AAC 15.920, I am not eligible for a medical deferment for the same condition.
9. All terms and conditions outlined in my Promissory Note are binding.
10. If my request is approved, ACPE will amend my repayment schedule, which will include capitalization of accrued interest. Payments are first applied to accrued, unpaid interest before being applied to principle.
11. I will inform ACPE if my condition improves and I no longer qualify for this deferment.
12. If approved, my deferment status will not begin more than 30 days prior to receipt of this completed form.
13. Deferments are granted for a maximum of six months. I must reapply for another deferment if the condition continues beyond that time.
14. Under 20 AAC 15.965, deferment requests in excess of five years for the same condition may require additional documentation.
15. If my deferment request is denied, all past due amounts are payable immediately. If alternate financial arrangements are necessary, I will contact ACPE at ACPE@alaska.gov or by using the address and phone numbers at the top of this form.

Name: ______________________________ SSN or Account Number: ______________________

Address: ______________________________ Home Phone: ______________________

City, State, Zip: ______________________________ Business Phone: ______________________

Certification: My signature certifies that I have read and understand the above facts relative to my 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 my 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 (M.D. or D.O., Surgeon, or Psychiatrist). Physician's medical office may be contacted.

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

1. Diagnosis or Condition:

____

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 ☐ Temporarily 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

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

____

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

Name of licensed physician (M.D., D.O., Surgeon or Psychiatrist only):	____________________	Phone Number:	____________________
Address:	____________________	City, State, Zip:	____________________
Degree Information:	____________________	Licensing State and Number:	____________________
[i]Signature of medical authority (M.D. or D.O.):	____________________	Date:	____________________

[i] If signed by a Physician's Assistant (PA-C), the supervising, licensed physician's (M.D., D.O., Surgeon or Psychiatrist) information must be provide, or the deferment request will be denied.