ACADEMIC STUDIES ABROAD

FINANCIAL AID VERIFICATION *(FAV)*

SECTION 1 – To be completed by the Student

ATTN STUDENTS: **This form is due by the Payment Deadline. Check your Billing Statement or call ASA at 617-327-9388.**

Student First & Last Name: _____ **College/University:** _____

INSTRUCTIONS: After completing Section 1, ask your college/university Financial Aid Office to complete Section 2 and then return the form to ASA. Ask them AT LEAST 2 WEEKS BEFORE THE PAYMENT DEADLINE. It usually takes this long.

IMPORTANT: Altering, revising, or modifying this form in any way after it has been completed by your college/university Financial Aid Office WILL RESULT IN IMMEDIATE DISMISSAL FROM THE ASA PROGRAM, WITH NO REFUND.

PLEASE READ CAREFULLY! *BY SIGNING HERE, I UNDERSTAND AND AGREE TO ALL OF THE FOLLOWING TERMS: I verify that I am submitting this form to ASA without alteration or revision, and I understand and agree that alteration or revision of this form will result in immediate dismissal from the ASA Program, with no refund. I understand that I may ONLY defer the amount shown below, and that I must pay in full to ASA any portion of the Program fees not covered by financial aid by the deadline indicated on my ASA Billing Statement. I understand that if I withdraw from the ASA Program after the posted payment deadline, or if for any reason my financial aid is reduced, cancelled, or unavailable, I am still responsible for paying all applicable ASA program costs and charges posted to my ASA account. I understand and agree that my financial aid/scholarship refunds and disbursements MUST be used ONLY for paying my ASA bill until my ASA bill is paid in full, and ONLY AFTER my ASA bill is paid in full can I use any leftover funds toward other expenses. Failure to comply with this policy may result in dismissal from the program.*

Student Signature: _____ **Date:** _____

SECTION 2 – To be completed by the college/university Financial Aid Office

The above-named student plans to use financial aid to pay for some or all of his/her ASA Program fees. Below, please verify the amount of financial aid the student has been approved to receive and the approximate date(s) the funds will be disbursed.

****PLEASE LIST ONLY APPROVED AMOUNTS – NOT ELIGIBILITY.**** **IF THE STUDENT'S FINANCIAL AID AWARD HAS NOT BEEN APPROVED, PLEASE COMPLETE THIS FORM AFTER IT HAS BEEN APPROVED.**

I, _____, a representative of the Financial Aid Office at _____
(Print First and Last Name) (College/University)

do hereby certify that the above-named student has been approved to receive a total of $_____ to be used to study abroad with ASA. This includes all federal aid, state aid, grants, scholarships, and loans that this office awards.

Funds are expected to be disbursed on or about:

1st disbursement *(If only one disbursement is expected, fill in this row only)*	Amount: $_____	Date: _____(m)/ _____(d)/ 20_____
2nd disbursement	Amount: $_____	Date: _____(m)/ _____(d)/ 20_____
3rd disbursement	Amount: $_____	Date: _____(m)/ _____(d)/ 20_____

To the best of my knowledge, the information above is true and accurate on this day, _____(m)/ _____(d)/ 20_____.

_____ _____
(Signature) (Title)

_____ _____
(Phone Number) (Email Address)

Please Email to: hello@academicstudies.com

Any questions, *please call ASA at 617-327-9388 or email hello@academicstudies.com.*