MIHL – ECSI

Request for Disability Deferment/Cancellation

A Mississippi Forgivable Loan debt may be deferred due to temporary disability. Debt may be cancelled due to total and permanent disability. To qualify for cancellation of a state student loan on the basis of total and permanent disability, the borrower must be unable to engage in any substantial gainful activity by reason of a medically determinable physical or mental impairment that can be expected to result in death, that has lasted for a continuous period of not less than 60 months, or that can be expected to last for a continuous period of not less than 60 months. A recipient is not considered totally and permanently disabled on the basis of a condition that existed before he/she applied for the loan, unless the recipient's condition has substantially deteriorated since he/she submitted the loan application, so as to render the recipient totally and permanently disabled.

PART I – TO BE COMPLETED BY THE BORROWER (COMPLETE IN INK)

Personal Information:

Last Name	First Name	Last Four of SSN (XXXX)
Street Address	City	State
Zip	Date of Birth	Email Address
Home Phone #	Cell Phone #	Work Phone #

I certify that all statements made are true and correct. I also certify that I will immediately notify the Mississippi Institutions of Higher Learning of any changes in my employment status. I authorize any physician, hospital, or other institution having records about the disability that is the basis for my request for cancellation to make information available in order to verify this application.

X ______________________________
Borrower's Signature Date

X ______________________________
Signature of Borrower's Legal Representative Date
(If borrower is unable to sign)

PART II – TO BE COMPLETED BY BORROWER'S ATTENDING PHYSICIAN

Disabling Condition:

______________________________ ______________________________
Providing Diagnosis Date of Providing Diagnosis

Present Condition (Check One): Recovered ______ Unchanged ______ Improved ______ Deteriorated ______

	Any Occupation	Regular Occupation
Is patient now totally disabled for:	YES ______ NO ______	YES______ NO_______
If NO, when is or was the patient able to work?	MM/DD/YY__________	MM/DD/YY__________
Will patient be able to resume work?	YES ______ NO ______	YES______ NO_______
If YES, when?	MM/DD/YY__________	MM/DD/YY__________

Physician Name	Physician License #	
Clinic/Hospital	Clinic/Hospital Street Address	
City, State, Zip	Telephone #	Fax #

I CERTIFY THAT THE INFORMATION STATED ABOVE IS CORRECT.

X ______________________________
Physician Signature Date

CONTACT:
Email: sfa@mississippi.edu
Phone: 800.327.2980 (toll-free) or 601.432.6997
Fax: 601.432.6527

RETURN FORM TO:
Office of Student Financial Aid
Mississippi Institutions of Higher Learning
3825 Ridgewood Road
Jackson, MS 39211

PART III FOR OFFICE USE
PROCESSED BY: ________________ DATE: _____________