Section A. Please answer these general questions.

1. Tell us why you are submitting this application. (You may check more than one box.)

☐ **Initial Certification.** This is a request for initial approval to participate in federal student financial aid programs and to be initially designated as an eligible institution for other Higher Education Amendments (HEA) programs.

☐ **Change in institutional ownership or structure.** This is a request to participate in federal student financial aid programs and to be designated as an eligible institution for other HEA programs following a change in institutional ownership or structure.

☐ Check here if requesting a preacquistion review.

☐ **Recertification**. This is a request to continue to participate in federal student financial aid programs and to continue to be designated as an eligible institution for other HEA programs either in response to a recertification notice from us or because your institution's Program Participation Agreement (PPA) will expire soon.

☐ **Designation as an eligible institution.** This is a request to be designated as an eligible institution so that your students may receive deferments under federal student loan programs or so that your institution may apply to participate in federal HEA programs other than Title IV student financial aid programs, including the Hope and Lifetime Learning Tax Credits.

☐ **Reinstatement.** This is a request to be reinstated to participate in federal student financial aid programs and/or to be redesignated as an eligible institution for other HEA programs.

☐ **Update/Other** (specify) _____

2. What is the name of your institution?

_____

3a. Do you have another name such as a trade name or a d/b/a name, under which you legally do business as a postsecondary educational institution?

☐ Yes ☐ No

If yes, what is that name?

_____

3b. During the last 4 years, have you had another name that you have not previously reported to the Department of Education?

☐ Yes ☐ No

If yes, what was that name?

4. ☐ Check here if you are an institution resulting from a merger in the past four years, and give the names and OPEID numbers of the former (pre-merger) institutions.

5. What are the first 6 digits of your 8-digit OPE ID number? The final 2 digits already are entered for you.

☐ Check here if you are an initial applicant and do not have an OPE ID number, and go to Question 6.

Current OPE ID (or former OPE ID if seeking reinstatement)

00

☐ Check here if you are an institution resulting from a merger in the past four years, and give the OPE ID numbers of the former (pre-merger) institutions.

00 00 00

6a. What is your 9-digit Taxpayer Identification Number (TIN) assigned by the IRS?

☐ Check here if you are an institution resulting from a merger in the past four years, and give the TINs of the former (pre-merger) institutions.

6b. What is your 9-digit DUNS number?

7. What was your most recently completed award year?

Beginning date: 07/01/____

Ending date: 06/30/____

8. What is your current award year?

Beginning date: 07/ 01/____

Ending date: 06/30/____

9. Does your institution have a web site (or home page) on the Internet?

☐ Yes ☐ No

If yes, list the electronic address (URL).

10. Who is your chief executive officer (CEO)/president/chancellor?

First name, Middle initial, Last name
(include prefix, such as Mr., Ms., Dr.)

Job title

Business street address

City

State (or province) and zip+4 (and country, if outside the U.S.)

Telephone number (including area code)

ext:

Fax number (including area code)

ext:

E-mail address (if applicable)

11. Who is your chief fiscal officer/financial officer?

First name, Middle initial, Last name
(include prefix, such as Mr., Ms., Dr.)

Job title

Business street address

City

State (or province) and zip+4 (and country, if outside the U.S.)

Telephone number (including area code)

ext:

Fax number (including area code)

ext:

E-mail address (if applicable)

12. Who is your financial aid director?
This must be a capable individual designated to be responsible for administering all the Title IV, HEA programs and coordinating those programs with the institution's other Federal and non-Federal programs of student financial assistance. (See 34 CFR 668.16)

First name, Middle initial, Last name
(include prefix, such as Mr., Ms., Dr)

Job title

Business street address

City

State (or province) and zip+4 (and country, if outside the U.S.)

Telephone number (including area code)

ext:

Fax number (including area code)

ext:

E-mail address (if applicable)

13. To whom do you wish us to send all ongoing correspondence and publications concerning federal student financial aid?

☐ Same person as in Question 10.

☐ Same person as in Question 12.

If neither of these people, complete the information below.

First name, Middle initial, Last name
(include prefix, such as Mr., Ms., Dr.)

Job title

Business street address

City

State (or province) and zip+4 (and country, if outside the U.S.)

Telephone number (including area code)

ext:

Fax number (including area code)

ext:

E-mail address (if applicable)

14. Whom should we contact at your institution if we have questions about information in this form.(Note: If there is someone you wish us to contact outside of your institution, you may enter them in question 70.)

☐ Same person as in Question 10.

☐ Same person as in Question 12.

☐ Same person as in Question 13.

If none of these people, complete the information below.

First name, Middle initial, Last name

(include prefix, such as Mr., Ms., Dr.)

Job title

Business street address

City

State (or province) and zip+4 (and country, if outside the U.S.)

Telephone number (including area code)

ext:

Fax number (including area code)

ext:

E-mail address (if applicable)

Section B. Please tell us about your accreditation and state authorization to provide postsecondary education.

☐ Check here if you are a foreign institution (including foreign graduate medical schools), and **go to Section C**.

15. What is your accrediting agency? (Complete **a.** if you have institution-wide accreditation; complete **b**. if you do **not** have institution-wide accreditation.)

a. If you have institution-wide accreditation, provide the following information for each agency. If more than one accrediting agency provides accreditation, designate the one you wish us to use in determining your eligibility and continued eligibility.

Abbreviation of accrediting agency *(A list of abbreviations accompanies this application.)*

You must include a copy of your current letter of accreditation.

- What year did your accrediting agency last accredit you?

- For how many years is this accreditation granted?

b. If you do **not** have institution-wide accreditation, provide the following information for each accrediting agency that either accredits a program that is currently eligible or for which you are seeking eligibility. (This includes programs such as a hospital-based nursing program or radiologic technology program.)

Abbreviation of accrediting agency *(A list of abbreviations accompanies this application.)*

You must include a copy of your current letter of accreditation.

- What year did your accrediting agency last accredit you?

- For how many years is this accreditation granted?

☐ Check here if you need space to give more than one answer and continue on a separate sheet. On the separate sheet, repeat the question being answered, numbering each sheet as page 1 of 3, page 2 of 3, and so on as appropriate for each question. Insert continuation sheets following the page where the question is asked.

16. ☐ Check here if you do not offer a flight program, and go to Question 17.

If you offer a flight program, provide your certification number from the U.S. Federal Aviation Administration (FAA).

Number

Date FAA certification expires

17. What state agencies authorize or license you to provide postsecondary educational programs? (For this question, do not include educational programs that are provided at "distance learning" sites.)

a. ☐ Check here if you are a public institution and do not provide at least 50% of an educational program outside your state, and go to Section C.

b. ☐ Check here if you are a public institution and you do provide at least 50% of an educational program outside your state, and list (for each state other than your "home" state) each state agency that licenses you, or otherwise provides you with legal authority, to provide postsecondary educational programs.

c. ☐ Check here if you are a private institution, and list each state agency that licenses you, or otherwise provides you with legal authority, to provide postsecondary educational programs.

d. ☐ Check here if you or your programs are not required to be authorized or licensed by a state agency, and include a copy of the basis for that determination.

Name of agency

Business street address

City

State (or province) and zip+4 (and country, if outside the U.S.)

Telephone number (including area code)

ext:

Fax number (including area code)

ext:

E-mail address (if applicable)

You must include a copy of your current state license(s) or other state authorization(s) and/or exemption(s).

☐ Check here if you need space to give more than one answer and continue on a separate sheet. On the separate sheet, repeat the question being answered, numbering each sheet as page 1 of 3, page 2 of 3, and so on as appropriate for each question. Insert continuation sheets following the page where the question is asked.

Section C. Please describe your institutional control and structure.

18. Check your type of institutional structure (check one).

☐ Public institution

☐ Private nonprofit 501(c)(3) institution
You must include a copy of your 501(c)(3) designation from the IRS.

☐ For-profit institution

Foreign institution (check one)

☐ Public institution

☐ Private nonprofit institution
You must include a certified English translation of your nonprofit designation status.

☐ For-profit institution (Note: Foreign graduate medical schools and foreign veterinary schools whose students complete their clinical training at an approved veterinary school in the U.S., are the only foreign for-profit institution eligible to apply to participate in in federal student financial aid programs.)

19. ☐ Check here if this is a request for initial certification, and go to Question 20.

For all other institutions, since you were last certified to participate in federal student financial aid programs, has your institutional structure checked in Question 18 changed?

☐ Yes ☐ No

If yes, give the date of the change.

20. ☐ Check here if you are a public institution, and **go to Section D.**

☐ Check here if you are not a public institution, and list the names of your board of trustees or your board of directors.

☐ Check here if you have a board of trustees.

☐ Check here if you have a board of directors.

☐ Check here if you have more than 10 on your board, and list only the board's executive committee and provide the name of a contact person in Question 21.

First name, Middle initial, Last name
(include prefix, such as Mr., Ms., Dr.)

21. If you provide only the board's executive committee in Question 20, tell us who is the appropriate person to contact for further information about your board (for example, the board's recording secretary)?

First name, Middle initial, Last name
(include prefix, such as Mr., Ms., Dr.)

Job title

Business street address

City

State (or province) and zip+4 (and country, if outside the U.S.)

Telephone number (including area code)

ext:

Fax number (including area code)

ext:

E-mail address (if applicable)

Section D. If you are a for-profit institution, or are a not-for-profit institution with a change in control, please answer these questions. (This includes for-profit foreign graduate medical schools.)

☐ Check here if you are **not** a for-profit institution, or are a not-for-profit institution that has not undergone a change in control and go to Section E.

22. Check the type of ownership you have (check one).

☐ Corporation - publicly traded

☐ Corporation - not publicly traded

☐ Partnership

☐ Proprietorship

23. If you are a corporation, give the name and address of the contact person (sometimes known as the "registered agent") within the state or foreign country where you are incorporated.

First name, Middle initial, Last name
(include prefix, such as Mr., Ms., Dr.)

Job title

Company name, if applicable

Business street address

City

State (or province) and zip+4 (and country, if outside the U.S.)

ext:

Fax number (including area code)

ext:

E-mail address (if applicable)

24. Provide the following information for each person or entity that directly or indirectly owns a 25% or greater interest in your institution.

a. The owner or person is (check one):

☐ a corporation (complete **b.** and **c.**)

- ☐ Publicly traded - Provide the stock exchange trading symbol _____
- ☐ Closely held corporation
- ☐ Subchapter S Corporation
- ☐ Limited Liability Company
- ☐ Other, identify _____

b. ☐ an unincorporated business entity (such as a partnership or trust) (complete **b.** and **c.**)

- ☐ General partner/partnership
- ☐ Limited liability partnership
- ☐ Proprietorship
- ☐ Voting trust
- ☐ Other, identify _____

☐ an individual (complete d.)

Name of corporation or other entity

Business street address

City

State (or province) and zip+4 (and country, if outside the U.S.)

Telephone number (including area code)

ext:

Fax number (including area code)

ext:

E-mail address (if applicable)

Percentage of ownership

Date ownership began

TIN

Identify the state or country in which you are located

c. List the following information for each person or entity that directly or indirectly owns a 25% or greater interest in this corporate owner or entity:

Name of owner

First name, Middle initial, Last name
(include prefix, such as Mr., Ms., Dr.)

Business street address

City

State (or province) and zip+4 (and country, if outside the U.S.)

Telephone number (including area code)

ext:

Fax number (including area code)

ext:

E-mail address (if applicable)

Home address

City

State (or province) and zip (and country, if outside the U.S.)

Percentage of ownership

Date ownership began

SSN of owner (required)

☐ Check here if you need space to give more than one answer and continue on a separate sheet. On the separate sheet, repeat the question being answered, numbering each sheet as page 1 of 3, page 2 of 3, and so on as appropriate for each question. Insert continuation sheets following the page where the question is asked.

d. If the owner is an individual (who holds ownership individually, or together with one or more members of his or her family, or in combination with others, such as a voting trust) provide the following information.

Name of owner

First name, Middle initial, Last name
(include prefix, such as Mr., Ms., Dr.)

Business street address

City

State (or province) and zip+4 (and country, if outside the U.S.)

Telephone number (including area code)

ext:

Fax number (including area code)

ext:

E-mail address (if applicable)

Percentage of ownership | Date ownership began | SSN of owner (required)

☐ Check here if you need space to give more than one answer and continue on a separate sheet. On the separate sheet, repeat the question being answered, numbering each sheet as page 1 of 3, page 2 of 3, and so on as appropriate for each question. Insert continuation sheets following the page where the question is asked.

25. Has a person or enitity listed in Question 24 or a member of that person's family or a director of your institution owned 25% or more or held a position listed below of another institution that is now partcipating in or ever particpated in federal student financial aid programs or of a third-party servicer listed in Question 58?

The ownership could be:

- individual, or
- held by one or more family members, or
- in combination with others, such as a voting trust.

The position held at another institution could be any of the following:

- member of the board of directors, or
- chief executive officer, or
- other executive officer, general partner or director of the institution or servicer.

☐ Yes ☐ No

If yes, what is the name of the owner (either the name of a person or an entity) or the director?
(If a person, include prefix, such as Mr., Ms., Dr.)

If applicable, what is the name of the third-party servicer that is or was owned?

If applicable, what is the name of the institution that is or was owned?

If applicable, what is the current or former OPE ID of this institution?

Is there any liability currently owed to the Department that was established during the period of ownership or position held? (If yes, please explain in Section K, Question 69)

☐ Yes ☐ No

☐ Check here if you need space to give more than one answer and continue on a separate sheet. On the separate sheet, repeat the question being answered, numbering each sheet as page 1 of 3, page 2 of 3, and so on as appropriate for each question. Insert continuation sheets following the page where the question is asked.

Section E. Please provide the following information for each educational program that you are requesting be eligible to participate in federal student financial aid programs.

26. Please check each box that describes the educational programs that you provide as of the date you submit this application or that you will provide during the current award year. **Provide information only on programs that you wish to be eligible for federal student financial aid.** (You may check more than one box.)

Note: The institution must be able to demonstrate a reasonable relationship between the length of the program and the entry-level requirement for the recognized occupation for which the program prepares the student. The Secretary considers the relationship to be reasonble if the number of clock hours provided in the program does not exceed by more than 50 percent the minimum number of clock hours required for training in the recognized occupation for which the program prepares the student, as established by the State in which the program is offered, if the state has established such a requirement, or as established by any Federal agency. If the program exceeds by more than 50 percent of the State or Federal minimum number of clock hours, please explain in Section K, Question 69.

Note: Post-baccalaureate students pursuing prerequisite coursework (such as prerequisite courses for medical school) have their eligibility determined on the basis of *student* eligibility for federal student financial aid criteria rather than *program* eligibility criteria. Therefore, these types of programs are not included here.

a. ☐ associate degree programs

b. ☐ bachelor's degree programs

c. ☐ master's degree programs or doctoral degree programs

d. ☐ first professional degree programs

e. ☐ graduate or professional programs that

- do not lead to a post-baccalaureate degree,
- are at least 10 weeks, and
- provide at least 8 semester or trimester credit hours, 12 quarter credit hours, or 300 clock hours of instruction.
- prepare students for gainful employment in a recognized occupation

f. ☐ two-academic-year transfer programs (*see glossary*)

g. ☐ undergraduate programs that

- lead to a certificate or other recognized educational credential,
- prepare students for gainful employment in a recognized occupation,
- are at least 15 weeks, and
- provide at least 16 semester or trimester credit hours, 24 quarter credit hours, or 600 clock hours of instruction.

h. ☐ undergraduate programs that

- lead to a certificate or other recognized educational credential,
- prepare students for gainful employment in a recognized occupation,
- are at least 10 weeks,
- provide at least 8 semester or trimester credit hours, 12 quarter credit hours, or 300 clock hours of instruction,

  AND
- require an enrolling regular student to have an associate degree or higher degree.

i. ☐ undergraduate programs that

- lead to a certificate or other recognized educational credential,
- prepare students for gainful employment in a recognized occupation,
- are at least 10 weeks,
- provide at least 300 but not more than 599 clock hours of instruction,
- do not exceed by more than 50% the minimum number of clock hours established by the state for such training programs, and
- have been provided for at least one year.

j. ☐ Post-baccalaureate teacher certification program necessary to become a teacher in an elementary or secondary school in that state. Please refer to the glossary for more information about this program type.

27. ☐ Check here if you award an associate degree, bachelor's degree, or higher degree to all your students who successfully complete any of your programs, and go to Question 28.

If you checked boxes e., g., h., or i. in Question 26, provide the following information.

a. If you checked box **e.** in Question 26, list the following information for each program.

Name of program

CIP code *(A list of CIP codes accompanies this application.)*

Number of weeks

Clock hours (number of hours) of instruction

Number of credit hours

Type (check one)

☐ semester credit hours ☐ trimester credit hours ☐ quarter credit hours

☐ Check here if you need space to give more than one answer and continue on a separate sheet. On the separate sheet, repeat the question being answered, numbering each sheet as page 1 of 3, page 2 of 3, and so on as appropriate for each question. Insert continuation sheets following the page where the question is asked.

b. If you checked boxes **g.** or **h**. in Question 26, list the following information for each program.

Name of program

CIP code *(A list of CIP codes accompanies this application.)*

Date first provided

Number of weeks

Clock hours (number of hours) of instruction *(This is required information.)*

If you offer the program in credit hours,
Number of credit hours

Type (check one)

☐ semester credit hours ☐ trimester credit hours ☐ quarter credit hours

Is each course within the program acceptable for full credit toward your associate degree or higher degree.

☐ Yes ☐ No

☐ Check here if you need space to give more than one answer and continue on a separate sheet. On the separate sheet, repeat the question being answered, numbering each sheet as page 1 of 3, page 2 of 3, and so on as appropriate for each question. Insert continuation sheets following the page where the question is asked.

c. If you checked box **i.** in Question 26, list the following information for each program.

Name of program

CIP code *(A list of CIP codes accompanies this application.)*

Date first provided

Number of weeks

Clock hours (number of hours) of instruction.

Maximum number of clock hours authorized by the state licensing agency

Completion rate*

Placement rate*

*Provide the completion rate and the placement rate for your most recently completed award year. (Instructions on how to calculate the completion rate are found in 34 CFR 668.8(f). Instructions on how to calculate the placement rate are found in 34 CFR 668.8(g).)

☐ Check here if you need space to give more than one answer and continue on a separate sheet. On the separate sheet, repeat the question being answered, numbering each sheet as page 1 of 3, page 2 of 3, and so on as appropriate for each question. Insert continuation sheets following the page where the question is asked.

28. Do you contract with an organization or ineligible institution (such as internship, externships, practicum in nursing, midwifery, medical technician, etc.) to provide more than 25% of any educational program?

Note: You cannot contract more than 50% of the program to an organization or ineligible institution, otherwise the program is not eligible for Title IV.

☐ Yes ☐ No

If yes, provide the following information.

a. Name of program

Name of organization or ineligible institution

Corporation name, if applicable

Business street address

City

State (or province) and zip+4 (and country, if outside the U.S.)

Former OPE ID number of the other institution, if applicable

You must include a copy of the approval from your accrediting agency for contracting this program.

b. ☐ Check here if any owner or person listed in Question 24 or Question 25 directly or indirectly

- owns or controls 25% or more of the ineligible institution

or

- serves as a director or as an executive officer of the ineligible institution.

What is the name of this owner or person?

c. Did the ineligible institution withdraw from participating in federal student financial aid programs under a termination, show cause, suspension, or similar type of proceeding initiated by its state licensing agency, accrediting agency, guarantor, or the U.S. Secretary of Education?

☐ Yes ☐ No

☐ Check here if you need space to give more than one answer and continue on a separate sheet. On the separate sheet, repeat the question being answered, numbering each sheet as page 1 of 3, page 2 of 3, and so on as appropriate for each question. Insert continuation sheets following the page where the question is asked.

Section F. Please tell us about your locations.

29. What is your principal location?

Name of location

Business street address

City

County

State (or province) and zip+4 (and country, if outside the U.S.)

30. Provide the following information for any of your locations (other than your principal location) that meet any one of these three criteria and at which you provide educational programs to students whom you wish to participate in federal student financial aid programs:

- It is a location where students could complete 50% or more of an educational program that you offer during the current award year.

or

- It is a location where students could complete at least 50% of an educational program over a two-year period (consisting of the current award year and the most recently completed award year).

or

- It is a location where you provide any educational programs if, during the past two-year period (consisting of the current award year and the most recently completed award year), you told students that they could complete at least 50% of any educational programs there.

Name of location

Business street address

City

County

State (or province) and zip+4 (and country, if outside the U.S.)

OPE ID number of location *or* if no OPE ID number, check here ☐

DUNS number

Would you like to receive mailings from the Department at this location?

☐ Yes ☐ No

☐ Check here if the mailing address is different from the address above, and provide the mailing address below.

Mailing address

City

State (or province) and zip+4 (and country, if outside the U.S.)

☐ Check here if you need space to give more than one answer and continue on a separate sheet. On the separate sheet, repeat the question being answered, numbering each sheet as page 1 of 3, page 2 of 3, and so on as appropriate for each question. Insert continuation sheets following the page where the question is asked.

Section G. Please tell us about your tele/corr courses, your students enrolled under ability-to-benefit provisions, and your incarcerated students.

31. For the most recently completed award year, were more than 50% of your courses taught by means of telecommunications and/or correspondence (tele/corr)? (See 34 CFR 600.2, 600.7, and 668.38)

Note: If a course is offered through traditional methods and through tele/corr, then that course should be counted under both traditional methods and tele/corr. Therefore, the same course might be counted more than once.

☐ Yes ☐ No

32. For the most recently completed award year, were 50% or more of your regular students enrolled in tele/corr courses? (See 34 CFR 600.2, 600.7, and 668.38)

☐ Yes ☐ No

33. During the most recently completed award year, were 50% or more of your regular students ability-to-benefit students? (See 34 CFR 600.7, and 668.32)

Note: Do not include students who are being educated at your institution under a specific contract with federal, state, or local governments for training purposes (such as most contracts under the Job Training Partnership Act).

☐ Yes ☐ No

34. During the most recently completed award year, were 25% or more of your regular students incarcerated? (See 34 CFR 600.2, 600.7, and 668.32)

☐ Yes ☐ No

Section H. Please complete this section if this is an initial application or you were certified but you have a change in your ownership or structure or you are seeking reinstatement.

☐ Check here if this is **not** an initial application or a change in ownership or structure or for reinstatement, and **go to Section I.**

Note: Here "change in ownership or structure" refers to a change in ownership, conversion to or from a non-profit institution, or a merger of two or more institutions.

> If you acquired the institution *or* if the institution is the result of a merger of two or more former institutions, you will be liable for any debts incurred by your predecessors under federal student financial aid programs.

35. Tell us why you are completing this section.

☐ This is an initial application and you are a new institution *without* a prior history. Enter your start date and answer Questions 36, 37, and 38, then **go to Section I**.

☐ This is an initial application and you are a new institution *with* a prior history (for example, you have been in operation for one or two years). Answer **all** the questions in this section.

Tell us on what date you were both legally authorized to provide and began continuously providing the education or training program(s) for which you are seeking eligibility.

Start Date

/ /

Note: If you are a for-profit institution or if you offer only a progam(s) of less than one academic year, you must have been in existence for at least two years to be eligible to participate in federal student financial aid programs. (See 34 CFR 600.5 and 600.6)

☐ You are an institution with a change in your ownership. Answer Questions 36, 37, and 38, then **go to Section I**.

☐ You are an institution that converted to a not-for-profit institution. Answer Questions 36, 37, and 38, then **go to Section I.**

☐ You are an institution that converted to a for-profit institution. Answer Questions 36, 37, and 38 then **go to Section I**.

☐ You are an institution resulting from a merger in the past four years. Answer Questions 36, 37, and 38 about the newly formed institution, then **go to Section I**.

☐ You are an institution seeking reinstatement. Answer all the questions in this section.

36. How many full-time equivalent (FTE) financial aid staff members do you have?

Administrative, counselors, or other professionals

FTE

Clerical

FTE

37. Indicate all of the federal student financial aid programs in which you are seeking approval to participate. (**Note:** Foreign institutions, including foreign graduate medical schools, may apply only for the Federal Family Education Loan [FFEL] Program.)

☐ **Federal Pell Grant Program**

☐ **Federal Perkins Loan Program**

☐ **Federal Supplemental Educational Opportunity Grant (FSEOG) Program**

Federal Work-Study (FWS) Program

Indicate specific programs within FWS for which you are seeking approval to participate.

☐ Federal Work-Study—regular or general

☐ Job Location and Development (JLD) Program

☐ Private-Sector Employment

Federal Family Education Loan (FFEL) Program

(formerly called the Guaranteed Student Loan Program)

Indicate specific programs within FFEL for which you are seeking approval to participate.

☐ Federal Stafford Loan Program (subsidized)

☐ Federal Stafford Loan Program (unsubsidized)

☐ Federal PLUS Loan Program (parent loans)

William D. Ford Federal Direct Loan Program (Direct Loan Program)

Indicate specific programs within the Direct Loan Program for which you are seeking approval to participate.

☐ Federal Direct Loan Program (subsidized)

☐ Federal Direct Loan Program (unsubsidized)

☐ Federal Direct PLUS Loan Program (parent loans)

38. Do you anticipate an increase of 10% or more in your student body in the next award year?

☐ Yes ☐ No

If yes, how many regular students do you estimate would be eligible to receive federal student financial aid for the remainder of the current award year and each of the next two award years if you become eligible to participate in federal student financial aid programs?

☐ Estimated number for the remainder of the current award year

☐ Estimated number for the next award year

☐ Estimated number for the award year following the next award year

39. Provide the following information about your regular students. (If a student drops out and then reenrolls, count the student each time.)

    a. How many regular students were enrolled at your institution during your most recently completed award year?

    b. How many regular students in **a.** dropped out during the 100% refund period during your most recently completed award year?

    c. How many regular students in **a.** dropped out after the 100% refund period during your most recently completed award year?

40. If you provide vocational programs, list all such educational programs (not classes):

    - that you have provided continuously for at least 24 months

    and

    - for which you would like regular students to be eligible for federal student financial aid.

    Name of program

Check here if you need space to give more answers and continue on a separate sheet. On the separate sheet, repeat the question being answered, numbering each sheet as page 1 of 3, page 2 of 3, and so on as appropriate for each question. Insert continuation sheets following the page where the question is asked.

Section I. If you are a foreign institution, please complete this section. (This includes foreign graduate medical schools.)

Check here if you are not a foreign institution, and **go to Section J.**

Note: If you are a foreign institution, you must **include a copy of your most recent catalog and a certified English translation (*see glossary*) of all sections dealing with degrees and programs provided at your institution.**

41. Do you admit as regular students only people who have a credential of secondary school completion or its recognized equivalent?

    Yes No

42. In the country where you are located, are you legally authorized to provide an educational program beyond the secondary school level?

☐ Yes ☐ No

You must include a copy of your legal authorization and its certified English translation.

If yes, what is the name and address of the agency or ministry within the country that enforces this authority?

Name of agency

Business street address

City

Country

Telephone number (Complete international telephone number)

ext:

Fax number (including area code)

ext:

E-mail address (if applicable)

43. Are you legally authorized to award a degree that is equivalent to an associate, baccalaureate, graduate, or professional degree awarded in the United States?

☐ Yes ☐ No

You must include a copy of your legal authorization and its certified English translation.

44. Do you provide an educational program that is at least a two-academic-year program acceptable for full credit toward the equivalent of a baccalaureate degree awarded in the United States?

☐ Yes ☐ No

45. Do you provide any educational programs that meet all three of these criteria?

- The program is equivalent to at least a one-academic-year training program in the United States.

and

- The program leads to a certificate, degree, or other educational credential that is equivalent to one offered in the United States.

and

- The program prepares students for gainful employment in an occupation that is equivalent to one in the United States.

☐ Yes ☐ No

46. Do you have administrative offices and/or recruiting offices in the United States that represent you?

☐ Yes ☐ No

If yes, provide the following information.

Name of office

Business street address

City

State and zip+4

Telephone number (including area code)

ext:

Fax number (including area code)

ext:

E-mail address (if applicable)

Name of contact person at the office:

First name, Middle initial, Last name
(include prefix, such as Mr., Ms., Dr.)

☐ Check here if you need space to give more than one answer and continue on a separate sheet. On the separate sheet, repeat the question being answered, numbering each sheet as page 1 of 3, page 2 of 3, and so on as appropriate for each question. Insert continuation sheets following the page where the question is asked.

☐ Check here if you are a foreign institution that is **not** a foreign graduate medical or veterinary school **and go to Section J.**

47. Where is the facility at which you provide graduate medical or veterinary educational program instruction in your country?

Name of facility

Address

City

Country

Telephone number (Complete international telephone number)

ext:

Fax number (including area code)

ext:

E-mail address (if applicable)

Name of contact person at the facility:

First name, Middle initial, Last name
(include prefix, such as Mr., Ms., Dr.)

☐ Check here if this is a veterinary school.

☐ Check here if you need space to give more than one answer and continue on a separate sheet. On the separate sheet, repeat the question being answered, numbering each sheet as page 1 of 3, page 2 of 3, and so on as appropriate for each question. Insert continuation sheets following the page where the question is asked.

48. What entity in your country is legally authorized to evaluate the quality of your graduate medical educational program?

Name of entity

Address

City

Country

Telephone number (Complete international telephone number)

ext:

Fax number (including area code)

ext:

E-mail address (if applicable)

Name of contact person at the entity:

First name, Middle initial, Last name

(include prefix, such as Mr., Ms., Dr.)

☐ Check here if you need space to give more than one answer and continue on a separate sheet. On the separate sheet, repeat the question being answered, numbering each sheet as page 1 of 3, page 2 of 3, and so on as appropriate for each question. Insert continuation sheets following the page where the question is asked.

49. Are you approved by the entity (or entities) listed in Question 48 to provide a graduate medical educational program in your country?

☐ Yes ☐ No

You must include a copy of each approval and its certified English translation.

50. What is the length of the program of graduate clinical and medical instruction?

☐ months

51. Is any part of your program of graduate clinical instruction provided in the United States?

☐ Yes ☐ No

If yes, provide the following information.

a. Name of facility

Business street address

City

State and zip+4

Telephone number (including area code)

ext:

Fax number (including area code)

ext:

E-mail address (if applicable)

Name of contact person at the facility:

First name, Middle initial, Last name
(include prefix, such as Mr., Ms., Dr.)

b. Part of program offered:

☐ Classroom ☐ Clinical

Do you provide the remainder of your program of graduate medical instruction in your country?

☐ Yes ☐ No

c. What medical licensing boards and evaluating bodies in the United States currently approved the clinical training in the United States?

d. Was your clinical training program in the United States approved as of January 1, 1992 by the state in which you offter it?

☐ Yes ☐ No

You must include a copy of the approval.

If yes, is it currently approved by the state?

☐ Yes ☐ No

You must include a copy of the approval.

☐ Check here if you need space to give more than one answer and continue on a separate sheet. On the separate sheet, repeat the question being answered, numbering each sheet as page 1 of 3, page 2 of 3, and so on as appropriate for each question. Insert continuation sheets following the page where the question is asked.

52. List the dates of graduation and the number of regular students who graduated within the past three 12-month periods.

Dates	Dates	Dates
Graduates	Graduates	Graduates

☐ Check here if you need space to give more than one answer and continue on a separate sheet. On the separate sheet, repeat the question being answered, numbering each sheet as page 1 of 3, page 2 of 3, and so on as appropriate for each question. Insert continuation sheets following the page where the question is asked.

53. What are the beginning and ending dates of your institution's most recently completed academic year?

Beginning date

Ending date

54. How many full-time regular students were enrolled during the most recently completed academic year?

55. How many of the regular students in Question 54 were not U.S. citizens or residents eligible for U.S. federal financial aid programs?

56. If your school is located in Canada, go to Section J. During the most recently completed academic year, how many of your regular students and graduates from the three preceding years took any "step" of the examinations administered by the Education Commission for Foreign Medical Graduates?

How many of these students received passing scores on any “step” of the examinations?

57. ☐ Check here if you are a foreign institution that is not a foreign veterinary school go to Section J.

☐ Check here if your students complete their clinical training at an approved veterinary school in the United States.

Name of US veterinary school

Business street address

City

State

Telephone number (including area code) & ext.

Ext.

Fax Number (including area code) & ext

Ext.

E-mail address (if applicable)

Section J. Please tell us about your third-party servicers. (This includes your Ability to Benefit Tester.)

58. If you contract with any third-party servicer or outside party to perform any function relating to federal student financial aid programs, provide the following information about each servicer

Identify which ability to benefit tester you use.

Note: Do not list independent auditors. Also do not list vendors that provide books, forms, or computer programs (in other words, do not list vendors unless they actually perform services or functions for which you are responsible under the HEA programs).

Name of servicer's contact person First name, Middle initial, Last name

(include prefix, such as Mr., Ms., Dr.)

Job title

Company name

Business street address

City

State (or province) and zip+4 (and country, if outside the U.S.)

Telephone number (including area code)

ext:

Fax number (including area code)

ext:

E-mail address (if applicable)

Indicate the service provided:

- ☐ Performing needs analysis
- ☐ Authorizing financial aid
- ☐ Disbursing financial aid
- ☐ Performing loan servicing
- ☐ Counseling/providing information for students
- ☐ Performing loan collection
- ☐ Preparing/maintaining student aid transcripts
- ☐ Other (specify)

☐ Check here if you need space to give more than one answer and continue on a separate sheet. On the separate sheet, repeat the question being answered, numbering each sheet as page 1 of 3, page 2 of 3, and so on as appropriate for each question. Insert continuation sheets following the page where the question is asked.

Section K. Please assure us of your administrative capability and your financial responsibility.

Note: To expand on any of your answers, use Question 69, or explain why the question was not answered.

59. Do you have a system of internal checks and balances for administering federal student financial aid that meets federal regulations? (See 34 CFR 668.16.)

☐ Yes

60. Do you divide the functions of determining student awards and disbursing funds that result from those award decisions? (See 34 CFR 668.16.)

☐ Yes

61. Do you have procedures that ensure frequent, periodic reconciliation of fiscal office and financial aid office award data? (See 34 CFR 668.14, 668.16, 668.24, 674.19, 675.19, 676.19, and 690.81.)

☐ Yes

62. Do you have a system to identify and resolve discrepancies in information you receive from various sources about a student's application for financial aid? (See 34 CFR 668.16.)

☐ Yes

63. Do you have a policy that meets federal regulations for requiring satisfactory academic progress for recipients of federal student financial aid? (See 34 CFR 668.16 and 668.34.)

☐ Yes

64. Do you have procedures that ensure that your requests for federal cash do not exceed the amount of funds you need immediately to make aid disbursements to students? (See 34 CFR 668.163.) (This question does not apply to foreign schools.)

☐ Yes

65. Do you have a policy that meets federal regulations for returning Title IV funds when a student withdraws from classes? (See 34 CFR 668.22.)

☐ Yes

66a. Have you submitted your required annual financial statement audits to us on time? (For initial applicants, have you established a process to ensure that you submit your required annual financial statement audit to us on time?) (See 34 CFR 668.23.)

☐ Yes

66b. Have you submitted your required annual federal student financial aid compliance audits to us on time? (For initial applicants, have you established a process to ensure that you submit your required annual federal student financial aid compliance audit to us on time?) (See 34 CFR 668.23.)

☐ Yes

67. Do you use the electronic processess required by the Secretary? (See 34 CF668.16)

☐ Yes

68. Do you have a process to insure you obtain the necessary approvals from the Department for expanding or re-establishing your institutional eligibility, (such as changes of ownership resulting in a change of control, excluded changes in ownership, or adding new locations in certain circumstances), and that you notify us within 10 days about other important changes (such as changing your name, address or official)? (See 34 CFR 600.10, 600.20 and 600.21)

☐ Yes

69. (Optional) Use this area if you need extra space to tell us about any unusual circumstances or to provide additional explanations about your application.

☐ Check here if you need additional space and continue on a separate sheet. On the separate sheet, repeat the question being answered, numbering each sheet as page 1 of 3, page 2 of 3, and so on as appropriate for each question. Insert continuation sheets following the page where the question is asked.

70 a. (Optional) Provide the following information for any person or firm outside your institution that you wish to designate as your agent to represent you in matters related to this application.

First name, Middle initial, Last name

(include prefix, such as Mr., Ms., Dr.)

Job Title

Company name

Business street address

City

State (or province) and zip+4 (and country, if outside the U.S.)

Telephone number (including area code)

ext:

Fax number (including area code)

ext:

E-mail address (if applicable)

70 b. Who is the official authorized to certify FFEL loan applications for your institution?

First name, Middle initial, Last name

(include prefix, such as Mr., Ms., Dr.)

Job Title

Company Name

Business street address

City

State (or province) and zip+4 (and country, if outside the U.S.)

Telephone number (including area code)

ext:

Fax number (including area code)

ext:

E-mail address (if applicable)

70 c. Who is your institution's destination point administrator (DPA)?

First name, Middle initial, Last name

(include prefix, such as Mr., Ms., Dr.)

Job Title

Company Name

Business street address

City

State (or province) and zip+4 (and country, if outside the U.S.)

Telephone number (including area code)

ext:

Fax number (including area code)

ext:

E-mail address (if applicable)

71. Identify gifts received from or contracts entered into with foreign sources that exceed $250,000 in the calendar year or it is owned or controlled by a foreign source.

Gift Type

Date received

(mm/dd/yyyy format)

Amount

Giver Name

Country

Contract Start Date

(mm/dd/yyyy format)

Contract End Date

(mm/dd/yyyy format)

Section L. Please have the appropriate person in authority review, sign, and date this document.

I hereby certify that, to the best of my knowledge and belief, all information in this document is true and correct. I understand that if my institution provides false or misleading information, (a) the U.S. Department of Education may deny the institution's request for eligibility to participate in federal student financial aid programs and/or revoke eligibility once it has been granted and (b) the institution may be liable for all federal student financial aid funds it or its students received. I also understand that I may be subject to a fine of not more than $25,000 or imprisonment of not more than five years, or both, for misinformation that is material to receipt and stewardship of federal student financial aid funds.

Signature of President/CEO/Chancellor

Date

Name of institution

Name of President/CEO/Chancellor

☐ Check here if this is the same person as in Question 10. If not, complete the information below.

Job title

Business street address

City

State (or province) and zip+4 (and country, if outside the U.S.)

Telephone number (including area code)

ext:

Fax number (including area code)

ext:

E-mail address (if applicable)

Section M. Please include copies of appropriate documents as part of your application.

Indicate all copies of documents you are including with this application.

- ☐ Current letter of accreditation and any attachments. (See Question 15)
  (Please Note: The accreditation certificate is not sufficient documentation)
- ☐ Valid state license or other state authorization (See Question 17)
- ☐ For private nonprofit institutions—501(c)(3) designation from the IRS (See Question 18)
- ☐ If your institution contracts with an organization or ineligible institution to provide more than 25% of any educational program—a copy of the approval from your accrediting agency for contracting this program (See Question 28)

For initial applicants (See Question 35)

- ☐ Audited financial statements for the (two) most recently completed fiscal year(s)

  Default management plan: Either

  - ☐ The default management plan recommended by the Secretary of Education. (check this box, do not include the plan); *or*
  - ☐ A default management plan other than the plan recommended by the Secretary of Education. (check this box, do not include theplan); *or*
  - ☐ The institution is exempt under 487(a)(14)(C) of the HEA from providing a default management plan.

For institutions with a change in ownership or structure (See Question 35)

- ☐ Audited financial statements of the institution's two most recently completed fiscal years that are prepared in accordance with Generally Accepted Accounting Principles (GAAP) and audited in accordane with Generally Accepted Government Auditing Standards (GAGAS); and
- ☐ Audited financial statements of the institution's new owner's two most recently completed fiscal years that are prepared in accordance with Generally Accepted Accounting Principles (GAAP) and audited in accordance with Generally Accepted Government Auditing Standards (GAGAS) or equivalent information for that owner that is acceptable to the Secretary.
- ☐ Same-day balance sheet, audited in accordance with GAGAS, showing the financial condition of the institution after the change in ownership.

  Default management plan: Either

  - ☐ The default management plan forth recommended by the Secretary of Education. (check this box, do not include the plan); *or*
  - ☐ A default management plan other than the plan recommeded by the Secretary of Education. (enclose a copy of the plan); *or*
  - ☐ The institution is exempt under 487(a)(14)(C) of the HEA from providing a default management plan.

For institutions seeking reinstatement (See Question 35)

☐ Audited financial statements for the two most recently completed fiscal years that are prepared in accordance with Generally Accepted Accounting Principles (GAAP) and audited in accordance with Generally Accepted Government Auditing Standards (GAGAS).

Default management plan: Either

☐ The default management plan recommended by the Secretary of Education. (check this box, do not include the plan); *or*

☐ A default management plan other than recommended by the Secretary of Education. (enclose a copy of the plan); *or*

☐ The institution is exempt under 487(a)(14)(C) of the HEA from providing a default management plan.

For foreign institutions, including foreign graduate medical schools

☐ For private nonprofit institutions—a certified English translation of nonprofit designation status (See Question 18)

☐ Most recent catalog and its certified English translation of all sections dealing with degrees and programs provided at your institution (See Section I)

☐ Legal authorization and its certified English translation to provide an educational program beyond the secondary school level in the country where you are located (See Question 42)

☐ Legal authorization and its certified English translation to award a degree that is equivalent to a degree awarded in the United States (See Question 43)

☐ Legal authorization and its certified English translation to provide graduate medical education (See Question 49)

☐ *In addition, if a foreign institution is an initial applicant*

☐ Audited financial statements for the two most recent years

Default management plan: Either

☐ The default management plan recommended by the Secretary of Education. (check this box, do not include the plan); *or*

☐ A default management plan other than the plan recommended by the Secretary of Education. (enclose a copy of the plan); *or*

☐ The institution is exempt under 487(a)(14)(C) of the HEA from providing a default management plan.