2025–2026 TPD & Substantial Gainful Activity Form

Elms College ● Financial Aid Office ● 291 Springfield Street, Chicopee, MA 01013
Phone: (413) 265-2249 ● Email: finaid@elms.edu

Why am I being asked to complete this form and what are my responsibilities?

The Financial Aid Office has been informed that you have one or more student loans and/or TEACH grants discharged due to Total and Permanent Disability (TPD). Because of this, you are not eligible to receive future federal student loans unless the form is completed by both the student and their physician confirming that you are eligible to engage in substantial gainful activity.
Please note: Section 2: Student Acknowledgement is required with each new loan, Elms College's Financial Aid Office only needs Section 3: Physician Acknowledgement to be completed once.

What are the Financial Aid Office's responsibilities?

The Financial Aid Office will review this form for eligibility for any federal student loans, and communicate to the student via email and/or phone regarding the outcome of their decision.

Section 1: Student's Information

Student's Last Name Student's First Name Student's M.I. _____

Elms College ID Number _____

Student's Street Address (include apt. no.) _____

Student's Date of Birth _____

City _____ State _____ Zip Code _____

Student's Phone Number _____

Section 2: Student Acknowledgement

I am a borrower whose prior loan(s) were discharged due to Total and Permanent Disability (TPD). I want to be considered for a federal student loan in the future, and I am able to participate in substantial gainful activity. I understand that these new loan(s) cannot be cancelled in the future on the basis of any injury or illness present at the time that the new loan is certified, unless my condition substantially changes and I meet the definition of total and permanent disability.

Student's Signature _____

Date _____

Section 3: Physician Acknowledgement

I certify that the individual referenced above is not of totally and permanently disabled at this time and is eligible to engage in substantial gainful employment.

Physician Name _____

License # _____

Date borrower became able to work & earn wages (MM/DD/YY) _____

Office Phone Number _____

Office Street Address _____

City _____ State _____ Zip Code _____

Physician's Signature _____

Date _____

WARNING: Each person signing this worksheet certifies that all the information reported is complete and correct. If you purposely give false or misleading information on this worksheet, you may be fined, be sentenced to jail, or both.