EXCELSIOR SCHOLARSHIP PROGRAM

APPEAL FORM

You were recently notified of your ineligibility for the Excelsior Scholarship. To appeal this decision, **you must complete sections I through III** and **have your physician/health care provider complete section IV,** if applicable, of this form. Send the completed form and all required documentation to: NYSDREAMEXCELappeals@applyists.com

***Please note that failure to provide all required information and documentation will result in a denial of your appeal.**

I. STUDENT INFORMATION (Required):

Name (Last, First, MI): _____

SSN (last four digits): _____ Date of birth: _____ /____ /_____

Email address: _____ Academic year:_____

Are you registered as an ADA student at your college? ☐ Yes **OR** ☐ No

I authorize any doctor, individual or entity with records concerning the basis of my appeal to release information and documentation to HESC and/or to speak with a HESC representative about matters related to this appeal with the sole purpose of determining award eligibility.

Student or Representative Signature:_____ Date: _____

II. BASIS OF APPEAL (Required) – Below, check the reason for your appeal, provide a brief personal statement explaining your circumstances and provide the required documentation indicated.

	Reason for Appeal	Documentation Required	Things to Note
☐	ADA Disability - Self	1. Section IV completed by physician/health care provider 2. Unofficial transcript	To qualify under ADA, you must be registered with your college as an ADA student. The break in attendance or decrease in credits must coincide with dates from your physician/ healthcare provider. Any additional documentation from physician/health care provider must be on official letterhead.
☐	Medical (non-ADA) - Self	1. Section IV completed by physician/health care provider 2. Unofficial transcript	The break in attendance or decrease in credits must coincide with dates from your physician/ health care provider. Any additional documentation from physician/health care provider must be on official letterhead.
☐	Care for Applicant's Newborn	1. Typed personal statement in space provided below 2. Birth Certificate	The break in attendance or decrease in credits must be within one year of newborn's birth.
☐	Medical – Care for Immediate Family Member	1. Typed personal statement in space provided below 2. Submit letter from physician/health care provider on official letterhead	Letter from health care provider must include all of the following: 1. Patient's diagnosis 2. Dates of care 3. Student's relationship to patient 4. Explanation of necessity for student to provide care to immediate family member

☐	Military - Self	1. Typed personal statement in space provided below 2. Department of Defense Orders	Personal statement below must include dates of service/deployment.
☐	Bereavement – Death of Immediate Family Member	1. Typed personal statement in space provided below. 2. Death Certificate and/or Copy of Obituary	Personal statement must include your relationship to the deceased. The break in attendance or decrease in credits must coincide with the date the immediate family member died.
☐	Other	1. Typed personal statement in space provided below 2. Submit any applicable supporting documentation	

Please provide a 300-word (max) personal statement describing the circumstances of your appeal below. Do not leave this section blank.

III. STUDENT AFFIRMATION (Required)

By my signature below, I affirm, under the penalty of perjury, that the information I provided in this Appeal Form and any supporting documentation submitted are true and complete and will be accepted for all purposes as the equivalent of a sworn affidavit.

Student Signature:_____ Date: _____

IV. MEDICAL INFORMATION – <u>To be filled out by the student's licensed physician/health care provider</u>.

The above patient is an applicant for a NYS scholarship administered by the Higher Education Services Corporation (HESC). For HESC to make an evaluation, please provide the following information. Use additional sheets, on physician/health care provider's letterhead, if necessary.

Please note: Failure to fully respond to any of the questions below may result in delays or denial of the student's appeal.

1. Please indicate how this student's disability or another medical condition impacted his/her college attendance:

   This student (*check one*) ☐reduced his/her college course load **<u>OR</u>** ☐stopped his/her college studies.

   This occurred from _____/_____/_____ to _____/_____/_____ .
   start date *end date*

   Please indicate any additional time periods and whether the student reduced his/her college course load or stopped college studies during those times on physician/health care provider's official letterhead.

2. Did the student change his/her major due to the medical condition? ☐ Yes ☐ No

3. Did the student change the college he/she attends due to the medical condition? ☐ Yes ☐ No

4. Briefly explain how/why this student's disability or other medical condition impacted his/her college attendance as you have indicated above:

_____

_____

_____

_____

PHYSICIAN/HEALTH CARE PROVIDER AFFIRMATION

By my signature below, I affirm, under the penalty of perjury that the information I provided in this Appeal Form is true and complete based on my professional medical judgment and the medical records maintained in the ordinary course of business.

_____ _____
Physician/Health Care Provider Signature Date

Print Name: _____

Address: _____

_____

Phone Number: _____

Physician's Stamp: