****

**EXCELSIOR SCHOLARSHIP PROGRAM ELIGIBILTY DETERMINATION FORM**

If you were recently notified by HESC that, since first enrolling in college, you (a) failed to complete at least 30 credits per year applicable to your degree program, or (b) failed to have enough credits accepted by your transfer college, or (c) failed to be continuously enrolled, you may still be eligible for an Excelsior Scholarship.

**Interruptions in Study.** By law, applicants who completed fewer credits than required and/or had a break in attendance due to (a) the death or illness of a family member, or (b) documented medical leave, or (c) active military service, or (d) parental leave, or (e) a disability as defined by the Americans With Disabilities Act of 1990, as amended, may still be determined eligible for an Excelsior Scholarship award.

If you meet one of these conditions, please complete **sections I through IV** below**.** If you had a medical diagnosis and were instructed to reduce your coursework or withdraw for a term by your physician or health care provider, you must **have your physician/health care provider complete section V**. Once all applicable sections have been completed, send the completed form and all required documentation to the ***Office of Financial Aid, 209 Maytum Hall, Fredonia, NY 14063 or appeals@fre***[***d***](https://www.hesc.ny.gov/ExcelsiorDetermination)***onia.edu***.

**\*Please note that all required information and documentation must be provided when submitting the Eligibility Determination Form. The eligibility determination made upon reviewing your documentation shall be based on the rules governing the Excelsior Scholarship and shall be the final agency determination.**

1. **STUDENT INFORMATION (Required):**
2. Last Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_First Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ MI: \_\_\_\_\_\_

 Fredonia ID number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. **The academic term & year the review request is for:**

Term/semester (i.e. Fall or Spring): \_\_\_\_\_\_\_\_\_\_\_Academic Year (i.e. 2022 etc.): \_\_\_\_\_\_\_\_\_\_

1. I have a disability under ADA and am registered with the office of Disability Support Services (DSS) on campus: [ ] Yes or [ ] No
2. **REASON FOR YOUR INTERRUPTION IN STUDIES (Required)** – Check one and provide the required documentation with your completed form.

|  |  |  |
| --- | --- | --- |
| **Condition**  | **Requirements**  | **Things to Note**  |
| □  | I have a disability under the ADA.  | To qualify under ADA, you must be registered with your college as an ADA student.  | HESC will verify that you are registered as an ADA student with your school.  |
| **Condition**  | **Requirements**  | **Things to Note**  |
| □  | I have/had a medical diagnosis that required that I leave school or attend less than full time.  | 1. Section III (see below)
2. Section V (completed by your physician/health care provider)
 | 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.  |
| □  | I took parental leave.  | 1. Section III (see below)
2. Provide Birth Certificate of newborn
 | The break in attendance or decrease in credits must be within one year of newborn’s birth.  |
| □  | An immediate family member was ill or experienced a major medical issue and I was unable to continue full-time for the term/semester I am requesting the review.  | 1. Section III (see below) | Ill family member or healthcare proxy must obtain documentation from health care provider stating that family member was under the care of the student. Documentation must be on official letterhead and include relationship to patient and dates in which supervision and/assistance was required.  |
| □  | I was called to active military duty.  | 1. Section III (see below)
2. Department of Defense Orders
 | Personal statement below must include dates of service/deployment.  |
| □  | Bereavement – Death of an immediate family member  | 1. Section III (see 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.  |

1. **PERSONAL STATEMENT (Required)**

Pleaseprovide by attaching a brief personal statement explaining the circumstances resulting in your interruption in studies which prevented you from meeting the eligibility requirements. ***The statement must be clear, dated and signed by the student.***

***Please note:*** *That circumstances other than those indicated above do not meet criteria as defined by State Education Law to enable you to retain your award.*

 **IV.** **STUDENT AFFIRMATION (Required)**

By my signature below, I affirm, under the penalty of perjury, that the information I provided, 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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**V. MEDICAL INFORMATION (To be completed by the licensed physician/health care provider)**

**To the student:** If you have indicated that you have/had a medical diagnosis that required that you to leave school or attend less than full time, your licensed physician/health care provider must complete this section.

**To the Physician/health care provider:**

The student named on this form is an applicant for a NYS scholarship administered by the Higher Education Services Corporation (HESC). For HESC to make an eligibility determination, please provide the following information. Use additional sheets, on physician/ health care provider’s letterhead, if necessary. Please complete section V in its entirety. Incomplete medical information may result in the denial of the student’s application.

1. Was it your medical recommendation that the student stop and/or reduce their college coursework based on his/her medical condition?

□ Yes □ No

1. Please indicate the period when the student’s medical condition impacted his/her college attendance:

□ This student needed to stop his/her college studies.

Effective Dates: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ through\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*start date end date*

**OR**

□ This student needed to reduce his/her college course load.

Effective Dates: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ through \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 *start date end date*

1. If applicable, did the student’s medical condition necessitate a change in his/her program of study?

□ Yes □ No

1. Did the student change the college he/she attends due to the medical condition? □ Yes □ No
2. Briefly explain how/why this student’s medical condition impacted his/her college attendance and if this student has any restrictions upon returning to his/her college studies. **The statement of explanation must be signed and on official letterhead.**

**PHYSICIAN/HEALTH CARE PROVIDER AFFIRMATION**

By my signature below, I affirm, under the penalty of perjury that the information I provided 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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |
| --- |
| **Physician’s Stamp: (Required)**  |

Professional License Number/State: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_