The 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. Upload the completed form using the CUNYfirst document uploader. Instructions for the document uploader can be found using the following link https://hunter.cuny.edu/students/registration/policies-and-forms/cuny_first-document-uploader/

*Please email Tap@hunter.cuny.edu once all documents have been uploaded.

*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):							
SS	SSN (last four digits):		of birth:				
Em	Email address:		Academic year:				
Are	Are you registered as an ADA student at your college? Yes OR No						
I a	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	Section IV completed by physician/health care provider 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	Section IV completed by physician/health care provider 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	Typed personal statement in space provided below Birth Certificate	The break in attendance or decrease in credits must be within one year of newborn's birth.				

	Military - Self	Typed personal statement in space provided below Department of Defense Orders	Personal statement below must include dates of service/deployment.
	Bereavement – Death of Immediate Family Member	Typed personal statement in space provided below. 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	Typed personal statement in space provided below Submit any applicable supporting documentation	
	se provide a 300-word w. Do not leave this se		ibing the circumstances of your appeal
III. S	STUDENT AFFIRMATIO	N (Required)	
	By my signature below, I Form and any supporting purposes as the equivale	documentation submitted are true	v, that the information I provided in this Appeal and complete and will be accepted for all
	Student Signature:		Date:

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

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.

I,	ttendance:					
	This student (check one) reduced his/her college course load OR stopped his/her college studies.					
	This occurred from to start date to					
	Please indicate any additional time periods and whether the stude or stopped college studies during those times on physician/health	nt reduced his/her college course load 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						
 Briefly explain how/why this student's disability or other medical condition impacted his/her of attendance as you have indicated above: 						
By my is true	ICIAN/HEALTH CARE PROVIDER AFFIRMATION signature below, I affirm, under the penalty of perjury that the infor and complete based on my professional medical judgment and the ry course of business.					
		Physician's Stamp:				
Physic	cian/Health Care Provider Signature Date					
Print N	Name:					
Addre	ss:					
Phone	Number:					