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/cunyfirst-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): ________________________________

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.

<table>
<thead>
<tr>
<th>Reason for Appeal</th>
<th>Documentation Required</th>
<th>Things to Note</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ ADA Disability - Self</td>
<td>1. Section IV completed by physician/health care provider 2. Unofficial transcript</td>
<td>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/health care provider. Any additional documentation from physician/health care provider must be on official letterhead.</td>
</tr>
<tr>
<td>☐ Medical (non-ADA) - Self</td>
<td>1. Section IV completed by physician/health care provider 2. Unofficial transcript</td>
<td>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.</td>
</tr>
<tr>
<td>☐ Care for Applicant’s Newborn</td>
<td>1. Typed personal statement in space provided below 2. Birth Certificate</td>
<td>The break in attendance or decrease in credits must be within one year of newborn's birth.</td>
</tr>
</tbody>
</table>
| 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 – 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.

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 OR ☐ 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: ________