Financial Aid Office
Submit form:
Document Submission Portal or by mail
PO Box 2000, Cortland, NY 13045-0900

2023-2024 Excelsior Scholarship Eligibility Appeal Form

Last Name First Name MI

C00_____
Cortland ID#

(_____)_____
Phone Number

_____
Term Appeal is for

Complete each of the following steps:

Step 1: Provide a typed statement explaining the extenuating circumstances beyond your control that prevented you from meeting the requirements (completing an average of at least 30 combined credits per year applicable to your degree program and/or continuous enrollment.) Please note that circumstances other than those indicated below do not meet criteria as defined by State Education Law to enable you to retain your award.

Step 2: Check the condition that applies and submit corresponding documentation	
☐ I have a disability under the ADA, and I am registered with SUNY Cortland Disability Resources Office.	1. Provide a statement from SUNY Cortland Disability Resources Office on letterhead stating your registration status. a. Personal statement from "Step 1" must include how your disability impeded your ability to complete all required credit hours.
☐ I have/had a medical diagnosis that required that I leave school or attend less than full time.	1. Attached "Medical Appeal Form" completed by your physician/health care provider. a. The break in attendance or decrease in credits must coincide with dates from your physician/health care provider. b. Any additional documentation from physician/health care provider must be on official letterhead.
☐ I took parental leave	1. Birth Certificate of child a. The break in attendance or decrease in credits must be within one year of newborn's birth.
☐ An immediate family member experienced a major medical issue, and I was unable to continue full-time.	1. Ill family member or healthcare proxy must obtain documentation from health care provider stating that family member was under the care of the student. a. 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. Department of Defense Orders a. Personal statement from "Step 1" must include dates of service/deployment.
☐ Bereavement – Death of an immediate family member	1. Death Certificate and/or Copy of Obituary a. 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.

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 an affidavit.

Student Signature: _____ Date: _____

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Medical Appeal Form

_____ C00_____
Last Name First Name MI Cortland ID#

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 the following.

To be filled out by your licensed physician/health care provider.

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

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

   This student needed to stop his/her college studies.

   This occurred from: _____ to _____
   start date *end date*

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

   This occurred from: _____ to _____
   start date *end date*

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

   Yes No

4. Did the student change the college he/she attends due to the medical condition?

   Yes No

5. 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.

Last Name First Name MI C00 Cortland ID

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