SUNY CORNING COMMUNITY COLLEGE

EXCELSIOR SCHOLARSHIP PROGRAM ELIGIBILITY DETERMINATION FORM

Student Name:_____ **CID:** _____

If you were recently notified that, since first enrolling in college, you (a) failed to complete an average of at least 30 combined credits per year applicable to your degree program, (b) failed to have sufficient credits accepted at SUNY Corning Community 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, (b) documented medical leave, (c) active military service, (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 unable to complete coursework, 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, please log into your student account and upload the completed form and all required documentation to the Financial Aid Secure Portal available here: https://www.corning-cc.edu/admissions-future-students/financial-aid/financial-aid-document-upload.php.

- **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 determination.**

I. PERSONAL STATEMENT (Required) – Please provide a brief personal statement explaining the circumstances resulting in your interruption in studies which prevented you from meeting the eligibility requirements.

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.

II. 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.	It will be verified with Access and Accommodations that you are registered as an ADA student.
☐	I have/had a medical diagnosis that required that I leave school, attend less than full time, or caused me to complete less than full-time credits.	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. Typed personal statement 2. Birth Certificate	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.	Detailed explanation of how extenuating circumstances beyond your control prevented you from meeting the requirements.	The 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. Typed personal statement 2. Department of Defense Orders	Personal statement below must include dates of service/deployment.
☐	Bereavement – Death of an immediate family member	1. Typed personal statement 3. 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.

III. 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: _____

IV. MEDICAL INFORMATION – if you have indicated that you have/had a medical diagnosis that required you to leave school or attend less than full time, your licensed physician/health care provider must complete this section.

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). In order 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

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.

V. 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

Professional License Number/State

Address

Phone Number

Physician's Stamp: (Required)