Suffolk
COUNTY COMMUNITY COLLEGE

Office of Financial Aid

Excelsior Scholarship Program—Eligibility Determination Form

If you were recently notified by HESC that, since first enrolling in college, you (a) failed to complete at least 30 credits applicable to your degree program per year, 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 a disability as defined by the Americans With Disabilities Act (ADA) 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, submit this form along with required supporting documentation to the Central Financial Aid Office.

Submit via Mail to:	Submit via Fax to:	Submit via Email to:
Central Financial Aid Norman F. Lechtrecker Bldg., Rm. 120 533 College Road Selden, NY 11784	(631) 451-4672	brewern@sunysuffolk.edu or bonpiek@sunysuffolk.edu

Section I: Student Information

Student Name: _____ **SCCC Student ID:** _____

Academic Year: _____ **Semester:** _____

I have a disability under ADA and am registered with Disability Services at SCCC: ☐ Yes ☐ No

Section II: Reason for Interruption in Studies

Check the condition(s) that apply and be sure to include the requirements for each one checked. Failure to do so will result in an automatic denial.

☐ **1. I have/had a medical diagnosis that required that I leave school or attend less than full-time.**

Complete: - Section III, Section V, and submit a Physician statement on how/why medical condition impacted college attendance.

Note: 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.

☐ **2. I took parental leave.**

Complete: Section III, and submit birth certificate for newborn.

Note: The break in attendance or decrease in credits must be within one year of the newborn's birth.

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☐ **3. 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.**

Complete: Section III, and submit documentation from health care provider of ill family member stating the family member was under the care of the student. Documentation must be on official letter head and include the relationship to patient and dates in which supervision and assistance was required of the student.

Note: A family member is defined as parent, sibling, child.

☐ **4. I was called to active military duty.**

Complete: Section III, and submit Department of Defense Orders.

Note: Personal Statement must include dates of service/deployment.

☐ **5. Bereavement- Death of an immediate family member (i.e. Step/Parent, Child, Spouse, Sibling or Grandparent).**

Complete: Section III, and submit death certificate or copy of obituary.

Note: 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.

Section III: Personal Statement

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

Note: Circumstances other than those indicated in Section II do not meet criteria as defined by State Education Law to enable you to retain your award.

Section IV: Student Affirmation

By signing below, I understand that all required information and documentation must be provided when submitting the Eligibility Determination Form initially.

The eligibility determination made upon review of this request shall be based on rules governing the Excelsior Scholarship and shall be final.

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:** _____

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Section V: Medical Information—To Be Completed by a Licensed Physician / Health Care Provider

To the student: 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 or health care provider must complete this section.

To the Physician/health care provider:
The student named on this form is an applicant for the NYS scholarship administered by the Higher Education Services Corporation (HESC). For the College to make an eligibility determination, please complete this section in its entirety. Incomplete medical information may result in the denial of the student's application. If additional information is necessary to include, please provide on your letterhead.

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/patient needed to stop his/her college studies.

   Effective dates: _____ through _____. **OR**

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

   Effective dates: _____ through_____.
3. 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. **The statement of explanation must be signed and on official office 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:_____ **Professional License#/State:**_____

Address:_____**Phone:**_____

Physician's Stamp (required):