SUPPLEMENTAL MEDICAL INFORMATION
EXCELSIOR SCHOLARSHIP APPEAL

New Paltz
STATE UNIVERSITY OF NEW YORK
Excelsior Scholarship Appeal Committee
200 Hawk Drive, New Paltz, NY 12561-2438
Ph: 845-257-3250 • Fax: 845-257-3568 • ExcelsiorDocs@newpaltz.edu

PATIENT INFORMATION & HIPAA AUTHORIZATION To be completed by the student.

Please sign and date to provide HIPAA authorization for your provider to share the requested information. Please also add your name and student ID number to the top of the next page. Your provider will complete the rest of the form.

_____ | N | | | | | | | | |

Fall or spring academic term that your interruption in study occurred (you may only list one term). Patient's Student ID Number

If your interruption in study lasted for more than one semester, you must submit one Supplemental Medical Information form for each term.

_____ _____

Patient Last Name First Name MI Suffix Patient Date of Birth

_____ _____

Patient Signature Date

PROFESSIONAL RECOMMENDATION To be completed by the licensed medical/mental health care provider.

The above patient is an applicant for the NYS Excelsior Scholarship administered by the New York State Higher Education Services Corporation (HESC). Due to their reduction in credits or break in enrollment, they are at risk of losing their scholarship eligibility.

To assist us with making an eligibility determination in line with New York State Education Law, please complete this form in its entirety. If necessary, you can use additional sheets on an official letterhead. Incomplete or missing information may result in the denial of the student's appeal.

1. Was it your professional recommendation that the above-named student reduce their college courseload and/or fully leave school due to their medical condition? If no, skip to question 3.

☐ Yes ☐ No

2. If you answered yes to the previous question, please indicate the period when the student's medical/mental health condition impacted their college attendance:

☐ This student needed to reduce their college courseload from: _____ (Start Date) to _____ (End Date)

☐ This student needed to stop their college studies from: _____ (Start Date) to _____ (End Date)

3. Did the student's condition necessitate a change in their program of study (change of major/minor/degree type)?

☐ Yes ☐ No

4. Did the student's condition necessitate a change in the college they attend (transferring)?

☐ Yes ☐ No

_____ _____

Provider Signature Date

Please continue to the next page.

Patient Last Name	First Name	MI	Suffix	N									Patient's Student ID Number

DIAGNOSIS To be completed by the licensed medical/mental health care provider.

Briefly explain this student's diagnosis, how/why the diagnosis impacted their college attendance, and if this student has any restrictions upon returning to their college studies.

PROVIDER INFORMATION

Please provide all requested information.

Provider Last Name | First Name | MI | Suffix

Practice/Hospital/Facility Name

Address

Phone Number

Provider License Number

Provider State of Licensure

Provider Stamp (Required):

PROVIDER AFFIRMATION

Please sign and date below to affirm that you understand the following:

- 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.

Provider Signature

Date

Submit the completed form(s) and required supporting documentation to us by:

Email (Preferred)
ExcelsiorDocs@newpaltz.edu

FAX
845-257-3568

In-Person
Wooster Hall 124

Mail
Student Financial Services
200 Hawk Drive
New Paltz, NY 12561-2437