NEW YORK STATE
HIGHER EDUCATION SERVICES CORPORATION

TOTAL AND PERMANENT DISABILITY VERIFICATION FORM

INSTRUCTIONS

- Section A is to be completed by the individual who will be receiving a NYS financial aid award (the Student).
- Section B is to be completed by the Student's spouse or parent who is totally and permanently disabled (the Family Member), if applicable.
- Section C is to be completed by the Student or Family Member who is totally and permanently disabled.
- Section D is to be completed by the medical doctor, healthcare professional, hospital or other institution having records about the Family Member's disability.

Your application will not be processed until this form has been completed and received at scholarships@hesc.ny.gov.

SECTION A: STUDENT INFORMATION (REQUIRED)	
Student's First Name: MI: Last Name:	
Student's Date of Birth: Student's SSN/ITIN (if one has been issued):	
Student's Signature: **X**	Date:
SECTION B: FAMILY MEMBER INFORMATION (REQUIRED IF FAMILY MEMBER IS DISABLED)	
Family Member's First Name: MI: Last Name:	
Family Member's Date of Birth: Family Member's SSN/ITIN (if one has been issued):	
Relationship of Family Member to Student: ☐ Spouse ☐ Mother ☐ Father	
Family Member's Signature: **X**	Date:
SECTION C: STUDENT OR FAMILY MEMBER DISABILITY INFORMATION (REQUIRED)	
I hereby authorize any medical doctor, healthcare professional, hospital or other institution having information about my disability that is the basis for the Medical Certification (Section D) to make such information available to the NYS Higher Education Services Corporation (HESC). I affirm, under the penalties of perjury under the laws of New York, that the information I have entered or submitted is true and complete ☐ Yes ☐ No	
Signature of individual completing Section C: **X**	Date:
SECTION D: MEDICAL CERTIFICATION (REQUIRED)	
Healthcare Professional's First Name: MI: Last Name:	
Name of Healthcare Practice:	
Street Address: City: State: Zip Code:	
Telephone Number: Fax Number: Email Address:	
I am a: ☐ Medical Doctor ☐ Psychologist ☐ Doctor of Osteopathy ☐ Chiropractor ☐ Other: Describe:	
State legally authorized to practice:	

HE9821 (9.2020)

License Number:
Diagnosis of present medical condition:
Date of diagnosis of disability:
Date individual was last seen by you:
Due to his or her diagnosis, the individual above is (select one): ☐ able to engage in an occupation for remuneration or profit on a full-time basis. ☐ able to engage in an occupation for remuneration or profit on a part-time basis. ☐ not able to engage in an occupation for remuneration or profit.
Describe how the medical condition prevents the above-named individual from engaging in any occupation for remuneration or profit, including part-time or light duty work, and if the individual's disability is expected to continue indefinitely:
I certify that all of the information I provide in this Certification is true and complete. ☐

Signature of Healthcare Professional: **X**	Date:

To be completed by HESC

Disability Status Confirmed: ☐ Yes ☐ No	Date:
Reviewed by:	Title of HESC Official:
Follow-up action assigned to:	