

Buffalo State University

Banner ID: _____

Student Phone: _____

Name: _____

Date of Birth: _____

New York State Higher Education Services Corporation (NYSHESC)

2025-2026 Excelsior Scholarship Annual Credit or Continuous Enrollment Appeal Form

Deadline Date: Friday, July 31, 2026

If you were recently notified of your ineligibility for the Excelsior Scholarship because you failed to meet the annual credit or continuous enrollment requirements, you may appeal if you meet one of the following conditions. Please be aware that only the circumstances indicated below will be considered as valid appeal reasons under State laws and regulations. **The eligibility determination made upon review of your documentation shall be based on the rules governing the NYS Excelsior Scholarship Program. Buffalo State's determination is final, and it cannot be appealed.**

Complete all sections of this appeal form and submit it, along with documentation, to finaid@buffalostate.edu. Appeals that do not have supporting documentation will be denied.

I. Basis of the Appeal

Check the appropriate boxes for your appeal and provide the required documentation.

	Reason	Required Documentation
	I have a disability under the ADA	To qualify under ADA, you MUST be registered with the university as an ADA student. HESC will verify that you are registered with the university.
<input type="checkbox"/>	Death of an immediate family member <input type="checkbox"/> Your parents (mother, father) <input type="checkbox"/> Your siblings (brothers, sisters) <input type="checkbox"/> Your children (sons, daughters) <input type="checkbox"/> Your maternal/paternal grandparents <input type="checkbox"/> Your spouse	Attach a copy of the obituary or death certificate. In your Personal Statement, include the name of the deceased and his/her relationship to you. Also, specify how this death impacted your ability to meet the annual credit and/or continuous enrollment requirement during the term specified.
<input type="checkbox"/>	Called to active military duty	Provide an official copy of your military orders. The dates of duties must be applicable to the academic term/year in which you failed to meet the annual credit and/or continuous enrollment requirement.
<input type="checkbox"/>	Interrupted your studies to take care of your new-born child (parental leave)	Provide child's birth certificate. The birth of the child must be applicable to the academic term/year in which you failed to meet the annual credit and/or continuous enrollment requirement.
<input type="checkbox"/>	Your medical or health care provider determines that your medical condition or mental health prevents you from beginning or continuing the term or from continuing a full- time course load.	Attach a written statement from a physician or medical professional on official letterhead and indicate the nature of the illness. You must include the dates of the illness or injury. Must be applicable to the academic term/year in which you failed to meet the annual credit and/or continuous enrollment requirement.

<input type="checkbox"/>	Interrupted your studies to care for an immediate family member, who's medical or health care provider has determined the need for additional support or care, which impacts your ability to begin or continue the term or from continuing a full-time course load.	Attach a written statement from a physician or medical professional on official letterhead and indicate the nature of the illness. You must include the dates of the illness or injury. Must be applicable to the academic term/year in which you failed to meet the annual credit and/or continuous enrollment requirement.
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II. Semester(s) Impacted

Indicate which semesters for which you are appealing (example: Fall 2024).

Fall 20_____

Spring 20_____

III. Explain What Happened

Briefly describe how you were impacted and address why you failed to remain continuously enrolled and/or why you did not earn at least 30 credits in the academic year. Will the issue continue to create a hardship? Attach a second page, if needed.

IV. Student Affirmation

By my signature below, I affirm, under penalty of perjury, 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.

I understand that my appeal may be denied, and this decision is final. If my appeal is denied, I further understand that my Excelsior eligibility will remain permanently terminated by NYSHESC.

Student Signature _____

Date _____

V. 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). For Buffalo State 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.

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)