State of Wisconsin
Higher Educational Aids Board

P.O. Box 7885
Madison, WI 53707-7885
E-Mail: HEABmail@wisconsin.gov

Telephone: (608) 267-2206
Fax: (608) 267-2808
Web Page: http://heab.wisconsin.gov

Scott Walker
Governor

John Reinemann
Executive Secretary

Wisconsin Hearing/Visually Handicapped Program

Student Name _____ Social Security # _____

Address: _____ Date of Birth _____

_____ County of Residence _____

I have resided at this address since (month and year) _____.
(If less than one year, use the back of this form to list residence information for the last 5 years.)

High School _____ _____ _____
Name City & State Year Graduated

I plan to enroll at _____ _____ _____
Name of Institution City & State Enrollment term (month & year)

Check student status: ☐ Undergraduate ☐ Graduate

Have you previously received a grant under this program? _____

Parent/Guardian _____ Resided here since (month & year) _____

(Address) _____ Telephone # (_____) _____

_____

_____ _____ (_____) _____
Student Signature Date Telephone Number

General Information

The Handicapped Student Grant Program was established to provide funding for undergraduate Wisconsin residents with a severe or profound hearing or visual impairment. Applicants must demonstrate financial need and be enrolled at least half-time at an in-state or eligible out-of-state public or independent higher education institution. For further details, please contact Cindy Cooley at (608) 266-0888 or e-mail to cindy.cooley@wisconsin.gov.

- Financial need is determined by the Financial Aid Administrator at the institution in which you enroll.
- The degree of hearing or visual impairment must be certified for first-time applicants.
  - Use the space on the back of this form for certification or attach a current audiogram or eye report.
  - Certification is not required if you have previously been awarded a grant under this program.
- The maximum award per academic year is $1800.

(Use back side of this form for examination certification)

Hearing/Visual Loss Certification - (To be completed and signed by examiner)

Visual Loss - Is the corrected vision 20/200 or less in the better eye? _____

Is the field of vision restricted to 20 degrees or less? _____

Hearing Loss - Is the hearing loss 40 decibels or greater in the better ear? _____

Other medical information that should be considered to determine eligibility for this grant.

_____

_____

_____

_____

EXAMINER NAME _____ _____

Examiner signature

Medical facility _____

Address _____ Date of exam _____

_____ Telephone # (_____) _____

To be forwarded by examiner to: Higher Educational Aids Board
HVHG Program
P. O. Box 7885
Madison, WI 53707-7885

Additional student residence documentation:

Address (Street address, city, state & zip)	**Dates of Residence** (month & year) - (month & year)		
_____	_____	to	_____
_____	_____	to	_____
_____	_____	to	_____
_____	_____	to	_____
_____	_____	to	_____
_____	_____	to	_____
_____	_____	to	_____