# 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**

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## 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 Sandra Thomas at (608) 266-0888 or e-mail to Sandy.Thomas@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)*

Handicap Grant Form (Rev. 9-02)
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:  State of Wisconsin
                       Higher Educational Aids Board
                       P. O. Box 7885
                       Madison, WI 53707-7885

Additional student residence documentation:

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<th>Address (Street address, city, state &amp; zip)</th>
<th>Dates of Residence (month &amp; year) - (month &amp; year)</th>
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