# State of Wisconsin
# Higher Educational Aids Board

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**Tony Evers**
Governor

**Connie Hutchison, PhD**
Executive Secretary


## WISCONSIN HEARING/VISUALLY IMPAIRED STUDENT GRANT PROGRAM

The Hearing/Visually Impaired 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.

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

For further details, please contact Charlene Sime at charlenek.sime@wi.gov or (608) 266-0888.

### Student Section

Academic Year: 20___ - 20___ Current Student Status: ☐ Graduate ☐ Undergraduate

Student Name: _____ Social Security #: _____
*Last* *First*

Phone: _____ Email: _____ Birthdate: _____

Current Address: _____
*Street Address* *Apartment/Unit #*

_____
*City* *State* *ZIP Code*

I have resided at this address since: _____ *If less than 1 year, use the back of this form to list residence information for the last 5 years*
*Month* *Year*

High School Attended: _____
*Name of High School* *City* *State* *Graduation/GED date*

I plan to Attend: _____
*Name of College/Institution* *City* *State* *Enrollment Term*

Have you previously received a grant under this program? ☐ YES ☐ NO If yes, what year(s)? _____

Parent/Guardian Name: _____ Phone Number: _____
*Last* *First*

Parent/Guardian Address: _____
*Street Address* *Apartment/Unit #*

_____
*City* *State* *ZIP Code*

Parent/Guardian has resided at this address since: _____
*Month* *Year*

Student Signature: _____ Date: _____ Phone: _____

## Examiner Section

### HEARING/VISUAL LOSS CERTIFICATION

**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: _____ Phone Number: _____

Examiner Signature: _____ Date of Exam: _____

Medical Facility: _____

Medical Facility Address: _____

*Street Address* *City* *State* *Zip Code*

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

## Additional Student Residence Documentation

*Students: If you've lived at your current address for less than 1 year, list residence information for the last 5 years below.*

Address: _____

*Street Address* *City* *State* *Zip Code*

Dates of Residence: _____ to _____

*Month* *Year* *Month* *Year*

Address: _____

*Street Address* *City* *State* *Zip Code*

Dates of Residence: _____ to _____

*Month* *Year* *Month* *Year*

Address: _____

*Street Address* *City* *State* *Zip Code*

Dates of Residence: _____ to _____

*Month* *Year* *Month* *Year*

Address: _____

*Street Address* *City* *State* *Zip Code*

Dates of Residence: _____ to _____

*Month* *Year* *Month* *Year*

Address: _____

*Street Address* *City* *State* *Zip Code*

Dates of Residence: _____ to _____

*Month* *Year* *Month* *Year*