



State of Wisconsin Higher Educational Aids Board

Tony Evers
Governor

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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
HVIIG 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