



Pennsylvania Higher Education Assistance Agency

# PA { BLIND OR DEAF BENEFICIARY GRANT PROGRAM 2016-17



PROVIDING FINANCIAL AID TO BLIND  
OR DEAF STUDENTS ATTENDING  
A POSTSECONDARY INSTITUTION



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# BLIND OR DEAF HIGHER EDUCATION

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## APPLICATION FORMS ■ 2016-17 ACADEMIC YEAR

### INSTRUCTIONS AND INFORMATION:

The following information is needed so that your application can be considered for the Blind or Deaf Higher Education Beneficiary Grant Program. If you need further information, please feel free to contact PHEAA staff at **800.692.7392** (TTY: Dial 711 for hearing impaired) or by email at **bdbg@pheaa.org**. You may also visit our website at **PHEAA.org**.

#### NEW APPLICANTS:

In order to qualify for the Program, new applicants must:

- Supply written documentation to PHEAA showing that the applicant has been evaluated and is eligible to receive benefits from the Pennsylvania Office of Vocational Rehabilitation (OVR). OVR may be reached at **866.375.8264**.  
OR
- Supply the completed Physician's Certification regarding the applicant's visual and/or hearing impairment (Page 4).
- Complete and return to PHEAA the 2016-17 Beneficiary Application Form.
- File a 2016-17 Free Application for Federal Student Aid (FAFSA®).
- Be a resident of Pennsylvania as of the first day of classes for each term for which Blind or Deaf funds are being requested.

#### RENEWAL APPLICANTS:

In order to be eligible as a renewal applicant for the Program, renewal applicants must:

- Complete and return to PHEAA the 2016-17 Beneficiary Applicant Form.
- File a 2016-17 Free Application for Federal Student Aid (FAFSA).
- Be a resident of Pennsylvania as of the first day of classes for each term for which Blind or Deaf funds are being requested.

#### INFORMATION ON THE PRIVACY ACT AND THE USE OF YOUR SOCIAL SECURITY NUMBER:

The Privacy Act of 1974 requires that each federal, state or local agency that asks for your Social Security Number or other information must tell you the following:

1. The agency's legal right to ask for the information and whether the law says you must give it;
2. What purpose the agency has in asking for it and how it will be used; and
3. What could happen if you do not give it.

The number is needed to be sure we know who you are, to process your application, and to keep track of your record. We use your Social Security Number in recording information about your college attendance; and in making sure you have received the benefit of this waiver. If you do not give us your Social Security Number, you will not receive a Program award.

Program applicants are hereby advised that disclosure of their Social Security Number is a requirement and a condition for participation in the Program. PHEAA, without such an identifier, would have difficulty in maintaining proper program records. Section 7(a)(2) of the Privacy Act provides that an agency may continue to require the disclosure of an individual's Social Security Number where the agency required this disclosure under statute or regulations prior to January 1, 1975, in order to verify the identity of the individual. Beginning in 1966 with Form S-1A-66 (First Application), applicants have been required to answer all questions completely or face disqualification for grant assistance. All subsequent forms utilized by PHEAA contain the Social Security Number as the identifier of the applicant, including eligibility announcements forwarded to the student and the financial aid officer of the postsecondary institution.

#### ALL APPLICANTS:

Mail or fax all required documentation by **March 31, 2017** to:

**PHEAA, State Grant and Special Programs**  
**P.O. Box 8157, Harrisburg, PA 17105-8157**  
**Fax: 717.720.3786**

**Applications will be considered only when all of the required documents have been received.**



Pennsylvania Higher Education Assistance Agency

# BLIND OR DEAF HIGHER EDUCATION

## BENEFICIARY APPLICATION FORM ■ 2016-17 ACADEMIC YEAR

<b>Check One:</b>		<b>New Applicant</b>		<b>Renewal Applicant</b>	
<b>Check All That Apply:</b>		<b>Blind</b>		<b>Deaf</b>	
<b>If Blind, Please Check Your Preferred Method of Communication:</b>			<b>Email</b>	<b>Large Print</b>	<b>Braille</b>
<b>Last Name:</b>	<b>First Name:</b>	<b>MI:</b>	<b>Social Security Number:</b>		
<b>Address:</b> <small>(P.O. Box must be accompanied by a street address)</small>	<b>City:</b>	<b>State:</b>	<b>ZIP:</b>		
<b>Telephone Number:</b> <b>Home:</b> <b>Other:</b>	<b>Email Address:</b>		<b>Date of Birth:</b>		
<b>College/University You Will Attend for 2016-17:</b>					
<b>College/University Street Address:</b>		<b>City:</b>	<b>State:</b>	<b>ZIP:</b>	
<b>Academic Level (check one):</b>	<b>Freshman</b>	<b>Sophomore</b>	<b>Junior</b>	<b>Senior</b>	<b>Graduate/Other</b>
<b>Enrollment Status:</b> <small>(As defined by the College/University you are attending for 2016-17. You must be enrolled at least half-time, as determined by your school, to be eligible for this Program.)</small>					
<b>Fall:</b>	<b>Full-time</b>	<b>Half-time</b>	<b>Less than Half-time or Not Enrolled</b>		
<b>Winter:</b>	<b>Full-time</b>	<b>Half-time</b>	<b>Less than Half-time or Not Enrolled</b>		
<b>Spring:</b>	<b>Full-time</b>	<b>Half-time</b>	<b>Less than Half-time or Not Enrolled</b>		
<p>By signing this application, I/we authorize PHEAA to make public announcement of any Program award or rejection of Program award made to the applicant, and to forward to the college/university which the applicant listed (or subsequently indicates that the applicant may attend) all information on any application and all information subsequently submitted to or acquired by PHEAA. I/we also authorize PHEAA and OVR to share information in their respective possession regarding this application and any Program award or rejection of Program award made to this applicant. For new applicants, I/we agree that I/we may provide evidence of the Program eligibility requirement of visual or hearing impairment in one of two ways: (1) by providing documentation to PHEAA of a determination made by OVR that the applicant is eligible for OVR benefits due to being blind or deaf; or (2) by returning the Physician's Certification form included with this application to PHEAA fully completed, meaning that one or more of the eligibility criteria has been chosen and the Physician's Certification is executed by a licensed physician. I/we agree that if I/we do not provide either the required eligibility documentation from OVR or the completed and executed Physician's Certification, both in the format as described in this application, the applicant will not be eligible for a Program award. I/we declare under penalty of the criminal laws of the Commonwealth of Pennsylvania that the application has been examined by me/us and to the best of my knowledge and belief, is a true, correct and complete application (see 24 P.S. § 5158.1 and 18 Pa.C.S.A. § 4904). I/we agree that the awarding of Program awards is based on various factors including available resources and that I/we may or may not receive a Program award regardless of eligibility for a Program award.</p>					
<b>Signature of Applicant:</b>				<b>Date:</b>	
<b>Parent or Legal Guardian Signature:</b> <small>(Required only if the applicant is less than 18 years of age)</small>				<b>Date:</b>	

<b>Applicant's Name:</b>			
Please indicate all that apply for the applicant referenced above:			
<b>BLINDNESS OR VISUAL IMPAIRMENT - ONE OR MORE OF THE FOLLOWING FACTORS:</b>			
<ul style="list-style-type: none"> <li>• A corrected visual acuity of 20/70 or greater in better eye</li> <li>• A visual field loss of 20 degrees or greater</li> <li>• A diagnosis of a progressive sight threatening disease</li> <li>• A significant functional limitation from vision loss</li> </ul>			
<b>DEAFNESS OR HEARING IMPAIRMENT:</b>			
<ul style="list-style-type: none"> <li>• Deafness, Primary Communication Visual:               <ul style="list-style-type: none"> <li>» A person has a significant hearing loss resulting in the need for manual communication, gesturing visual communication and other visual cues. For the ordinary purposes of life, the individual is unable to discriminate spoken language or sounds.</li> </ul> </li> <li>• Deafness, Primary Communication Auditory:               <ul style="list-style-type: none"> <li>» A person has a significant hearing loss resulting in the need for amplification, speech reading and the combination of auditory and visual cues. For the ordinary purposes of life, the individual is unable to utilize residual hearing alone in the understanding and discrimination of sounds and spoken language.</li> </ul> </li> </ul>			
<b>HARD OF HEARING (PRIMARY COMMUNICATION VISUAL OR AUDITORY):</b>			
<ul style="list-style-type: none"> <li>• A person, who is hard of hearing, does not depend entirely on visual communication and can hear in some environments, discriminate sound.</li> </ul>			
<b>DEAF-BLINDNESS: A PERSON WHO IS DEAF-BLIND MEANS ANY INDIVIDUAL:</b>			
<ul style="list-style-type: none"> <li>• Who has a central visual acuity of 20/200 or less in the better eye with corrective lenses, or a field defect such that the peripheral diameter of visual field subtends an angular distance no greater than 20 degrees, or a progressive visual loss having a prognosis leading to these conditions; and</li> <li>• Who has a chronic hearing impairment so severe that most speech cannot be understood with optimum amplification, or a progressive hearing loss having a prognosis leading to this condition; and</li> <li>• For whom the combination of impairments described in the above bullets cause extreme difficulty in attaining independence in daily life activities, achieving psychosocial adjustment, or obtaining a vocation; and</li> <li>• Who despite the inability to be measured accurately for hearing and vision loss due to cognitive or behavioral constraints, or both, can be determined through functional and performance assessment to have severe hearing and visual disabilities that cause extreme difficulty in attaining independence in daily life activities, achieving psychosocial adjustment, or obtaining vocational objectives.</li> </ul>			
<b>I CERTIFY THAT THE APPLICANT LISTED ABOVE MEETS THE CRITERIA THAT IS SELECTED ABOVE.</b>			
I am a doctor of (check one): <b>Medicine</b> <b>Osteopathy/Osteopathic Medicine</b>			
<b>Physician's Professional License Number:</b> (subject to verification through state records)			
<b>Physician's Signature:</b> (stamp is not acceptable)			<b>Date:</b>
<b>Printed Name of Physician:</b> (first name, middle initial, last name):			
<b>Address:</b>	<b>City :</b>	<b>State:</b>	<b>ZIP:</b>
<b>Telephone Number:</b>	<b>Email Address:</b>		
<b>Fax:</b>			