Inver Hills
Community College

Tuition Waiver/Assistance for Blind or Deaf Students Application

If you are a blind or deaf student with Minnesota residency, you may be eligible for a tuition waiver or partial tuition assistance. Complete all sections of this application for consideration. Your physician, ophthalmologist, and/or disabilities services specialist must certify your disability by completing the disability certification below. You must meet the criteria specified below for your circumstances.

- **Blindness:** You are eligible for a full tuition waiver if you are a legally blind, Minnesota resident. Your vision must be no better than 20/200 or 20 degrees of visual field in the better eye to be eligible for a full tuition waiver. Periodic exams will be required if visual impairment is temporary.
- **Deafness:** For partial assistance you must be a Minnesota resident with a hearing loss of such severity that you are primarily dependent on visual communication, such as writing, lip reading, manual communication and gestures. You must complete the Free Application for Federal Student Aid (FAFSA) that applies to the enrollment period of the tuition assistance and receive either a Federal Pell Grant or Minnesota State Grant for the term.

Student Information

Name (last, first, middle initial)	Student ID Number
Campus E-mail	Phone Number

Disability Certification

Your Physician, ophthalmologist, and/or disability services specialist must complete and sign this application.

1. Check the condition that you have observed in the student. ___ blindness ___ deafness
2. Check the condition as temporary or permanent. ___ temporary ___ permanent
3. Certify with your signature that, in your professional opinion, the student meets the criteria to qualify for tuition and fee assistance.

Student Name (first, middle initial, last)	Name of affiliated clinic or hospital
Clinic or hospital address (street, city, state, ZIP)	Phone (with area code)
Print name and title of physician or ophthalmologist	
Signature of physician or ophthalmologist	Date
Print name and title of disability services specialist	
Signature of disability services specialist	Date

Student Certification

By signing this form, I certify that all the information on this form is complete and correct.

Misrepresentation of facts in connection with this application may be sufficient cause, in and of itself, for cancellation or repayment of financial aid, whenever discovered.

Student Signature	Date