

Central Lakes College

Brainerd Campus
501 West College Drive
Brainerd, MN 56401
Phone: (218) 855-8175
Toll-Free: 800-933-0346
Fax: 218-855-8267

Office of Disabilities
Paula Huss- Coordinator
Office C111c

Staples Campus
1830 Airport Road
Staples, MN 56479
Phone: (218) 894-5182
Toll-Free: 800-247-6836
Fax: 218-894-5185

TTY users call Minnesota Relay Services 7-1-1 or 800-627-3529

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 dependant 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.

| Disability Certification (continued) | |
|--|---------------------------------------|
| Student Name (first, middle initial, last) (print legibly) | Name of affiliated clinic or hospital |
| Clinic or hospital address (street, city, state, ZIP code) | 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. <i>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.</i> | |
| Student Signature | Date |