



Need Assistance?
Contact the Financial Aid Office
1290 North Ave
Cleveland, WI 53015
Toll Free: 1.888.GOTOLTC, ext.
1718
Email: financial.aid@gotoltc.edu
Fax: 920.693.1834

2022-2023 Eligibility Reinstatement Form After A Previous Total and Permanent Disability

ACKNOWLEDGEMENT OF TOTAL AND PERMANENT DISABILITY DISCHARGE

This form serves to reestablish your eligibility for Federal Student Loan Programs when prior loans have been discharged due to total and permanent disability. Completion of this form does not guarantee that you will qualify for the Federal Student Loan Program.

First Name (Please Print)

Last Name

Student ID

I understand and affirm that I am a borrower whose prior loan was discharged due to a total and permanent disability based on a determination by the U.S. Department of Education. I now wish to take out another Federal Student Loan. I understand that I must obtain a physician's certification that I have the ability to engage in substantial gainful activity and submit that to the LTC Financial Aid Office. (See second page of this document)

I further understand that pursuant to Department of Education guidelines, any new Federal Student Loan obligation that I am awarded cannot later be discharged for any present impairment unless it deteriorates so that I am again totally and permanently disabled.

Additionally, I acknowledge that if I request a new Federal Student Loan during my three (3) year Post Discharge monitoring period the terms and conditions of my prior loan(s) that were subject to the discharge will be reinstated.

CONSENT FOR RELEASE OF INFORMATION: I authorize any physician, hospital, or other institution having records pertaining to the disability for which I previously received cancellation of my loan(s) to make information from such records available to Lakeshore Technical College, the U.S. Department of Education, or to the holder of my loan(s)

By signing this statement, I certify under penalty of perjury that the information I have reported on this forms is complete and accurate. I understand that purposely giving false or misleading information to qualify for federal student aid is a federal offense that can result in fines and/or incarceration.

Signature _____

Date _____

Printed Name _____

Return completed form to the Financial Aid Office.

PHYSICIAN CERTIFICATION OF BORROWER'S SUBSTANTIAL GAINFUL ACTIVITY

The student listed below has previously had Federal Student Loans discharged due to permanent and total disability claim approved by the U.S. Department of Education. The student is now applying for a new Federal Student Loan for attendance at Lakeshore Technical College. Per Department of Education guidelines, the student is required to obtain a physician's certification that they have the ability to engage in substantial gainful activity. The phrase "substantial gainful activity" means a level of work performed for pay that involves doing significant physical or mental activities or a combination of both.

Student Name: _____

Student ID: _____

INSTRUCTIONS FOR PHYSICIAN

- Complete this form only if you are a doctor of medicine or osteopathy legally authorized to practice in a state (see definition below)
- Type or print in dark ink. All fields must be completed, if applicable.
- If you make any changes to the information you provide in this form, you must initial each change.
- Please return the completed form to the student for processing their new Federal Student Loan.

PHYSICIAN'S CERTIFICATION

- I certify that, in my best professional judgment, the student identified above is___/is not___ capable of engaging in substantial gainful activity. If the student is able to work, and earn money in any capacity in any field of work, even if only on a limited basis, you must indicate that the student is capable of engaging in substantial gainful activity.
- I understand that a student who is currently able or who is expected to be able to work and earn money in *any* capacity in *any* field of work, even on a limited basis, does not have a total and permanent disability as determined by the U.S. Department of Education.
- I am a doctor of (check one) medicine ___/osteopathic medicine___. I am legally authorized to practice in the State of _____ and my professional license number is _____.

Physician's Signature (a signature stamp is not acceptable)

Date (mm-dd-yyyy)

Printed Name of Physician

Street Address

City, State, Zip

Telephone

Fax

Return completed form to the Financial Aid Office.