ADA “Intake Form”

**REQUEST FOR ACCOMMODATIONS AND SERVICES FORM**

**Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date of Request:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**UOG Student ID No.:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Not Applicable

**Semester √**: Fall Fall Intersession Spring Summer A B C Year \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Class √**: Freshman Sophomore Junior Senior Graduate. Visitor

**Major: Minor:**

**Projected Semester and Year of graduation:**

**Home Address:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(City, State/Island, Zip)

**Mailing Address: Same as above**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(City, State/Island, Zip)

**Check Mark Preferred Method for Contact**

 **Home Phone** (\_\_ \_\_ \_\_) \_\_ \_\_ \_\_ -\_\_ \_\_ \_\_ \_\_ **Cell Phone** (\_\_ \_\_ \_\_) \_\_ \_\_ \_\_ -\_\_ \_\_ \_\_ \_\_

 **UoG Email Address:**

**Email Address:**

**Date of Birth**: \_\_\_\_\_ /\_\_\_\_\_ /\_\_\_\_\_\_\_\_ **Social Security Last Four Digits**: \_\_ \_\_ \_\_ \_\_

**Emergency Contact 1:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone (\_\_ \_\_ \_\_) \_\_ \_\_ \_\_-\_\_ \_\_ \_\_ \_\_

Address:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Emergency Contact 2:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone (\_\_ \_\_ \_\_) \_\_ \_\_ \_\_-\_\_ \_\_ \_\_ \_\_

Address:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Primary Disability:**

**Other Disability(ies):**

**Do you have documentation of your disability? Yes No Submitted/attached**

**Type of Accommodation requested:**

* Priority registration for courses
* Extended Time on exam(s) and/or quiz(zes)
* Extended time on assignment(s)
* Alternative but equivalent Assignment(s)
* Preferential and accessible seating
* Note taking
* Sign Language Interpreter
* Use of Assistive Technology
* Emotional Wellness
* University Resources, services and programs
* Professor assistance, Please specify below
* Other, Please specify below

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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|  |
| --- |
| **Would you like Faculty Notification Letters (FNLs) prepared for your class(es), *which will be emailed to your instructors*?** YES\_\_\_\_\_ NO\_\_\_\_\_\_ **Provide a copy of your registration form, professor email addresses and indicate the course(s) you are requesting a FNL to be written.** |

**Have you received accommodations specific to your disability(ies) in the past?**

YES\_\_\_ NO\_\_\_

**Provide any additional information below :**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Received:**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**ADA Staff**

Student Request for

Disability Accommodation and Services

(To be completed by Student )

Your Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Semester and year first entered the University: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Degree Program: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Academic Advisor: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. What is your disability? Please specify the date your disability commenced and its expected duration. [Attach supporting document]
2. What is the reasonable accommodation(s) that you are requesting? Be as clear and specific as possible.
3. Please explain how the requested accommodation, aid or assistance measure will help you to attend the University and participate successfully in your degree program.
4. Please explain if there are **other** accommodations, aids or assistance measures which may assist you to attend the University and fulfill the requirements of your degree program.
5. If you are requesting for a Note Taker, Book Reader, and/or a Sign Language Interpreter, please indicate if you prefer to meet with your Service Provider on or before classes begins.

\_\_\_\_\_Yes \_\_\_\_\_ No

1. Are there any elements of your program of study that you cannot complete **without** the accommodation you are requesting? If so, please explain.
2. Are there any elements of your program of study that you cannot complete **even with** the accommodation you are requesting?

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, request that the above accommodations be provided to me as a qualified student with a disability. I further understand that the University of Guam will reasonably accommodate individuals with disabilities, as defined by applicable law, if the individual is otherwise qualified to meet the fundamental requirements and aspects of the program of the University, without undue hardship to the University.

The information that I have provided is true, correct, and complete. I hereby authorize, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, my treating physician and/or other related health care professional(s) to provide information regarding my condition to the University of Guam to assist in identifying and providing me with the accommodation(s) requested.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Student Date

VERIFICATION OF DISABILITY

[For New Students]

Please attach using official letterhead of your health provider a statement that certifies the following:

1. Name of Student/Applicant (“individual”) and Date of Birth
2. The nature of any physical or mental impairment experienced by the Individual.
3. How the impairment limits one or more of the individual’s major life activities.
4. The onset and expected duration of the disability.
5. Recommendations regarding the type of assistance needed for the Individual to participate as a student at the university.

**The name of the professional providing the verification, title, contact information, and signature should also be noted.**

**Types of documentation can include:**

• Psycho-educational evaluations

• Neuro-psychological evaluations

• Diagnostic summary letters from an appropriate medical professional (e.g. medical specialist, psychiatrist, audiologist)

• Medical records

• Recent Individualized Education Plans (IEPs), 504 Plans, or similar secondary school-based documents.

 NOTE: School-based documents such as an IEP, a 504 Plan, a Transition Plan, or a Summary of Performance without diagnostic information may not by itself provide sufficient information to determine eligibility for services.

Health Care Professional Section

(To be completed by Health Care Professional

Please attach additional pages and supporting documents, if necessary.)

**Student’s Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please complete the Verification of Disability portion or note here if the student is not a qualified person with a disability.

1. Please identify the specific diagnosis and description of the above-named student’s disability, to include the date the disability commenced and its expected duration. For the diagnosis of a specific learning disability, objective evidence of a substantial limitation to learning must be provided. Your evaluation must address areas including aptitude, achievement, and information processing and must include relevant records.
2. What is the reasonable accommodation(s) that you are recommending? Be as clear and concise as possible.
3. Please explain how the requested accommodation, aid or assistance measure will be effective in enabling the student to complete the student’s degree program at the University.
4. Please explain if there are other accommodations, aids or assistance measures that will enable the student to complete his/her degree program.
5. Are there any elements of the student’s program of study that the student cannot complete **without** this accommodation? If so, please explain.
6. Are there any elements of the student’s program of study that the student cannot complete **even with** this accommodation? If so, please explain.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Name of Health Care Professional Signature of Health Care Professional**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Clinic/Hospital Name Address**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Telephone Number**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Date**

STUDENT CONSENT/AGREEMENT and

# AUTHORIZATION TO RELEASE INFORMATION FORM

**Informed Consent for Release of Disability Information**

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, authorize and permit the Student Counseling and Advising Services Accommodations Services to discuss, either in writing or orally, and to release information about myself and/or related to my disability to appropriate administrators, instructors, professors, and other third-party professionals or service providers, as deemed necessary by SCAS/AS staff, and for the purpose of providing and/or coordinating accommodations and services for me.

I understand that every effort will be made to protect the confidentiality of information I provide, however, if it is determined that I may pose a danger to myself or others, in accordance with legal and ethical standards, confidentiality may be breached. I also understand that appropriate information may also be disclosed in the event of a medical emergency.

I understand that I may cancel or withdraw this authorization in writing at any time by notifying the Student Counseling and Advising Services Accommodations Services office. I understand that such withdrawal may adversely affect or prevent the University’s ability to provide the requested accommodations. Otherwise, this document will remain in effect at all times during my enrollment at the institution, unless an expiration date is provided otherwise.

**Please initial beside each statement as you agree to the following:**

 I understand that the purpose of the Student Counseling and Advising Services Accommodation

office is to address access barriers, which may vary from course to course. Therefore, accommodations may not be application in courses where there is no access barrier.

 Academic accommodations cannot fundamentally alter essential course or degree requirements.

 I understand my responsibilities to notify the Student Counseling and Advising Service

Accommodations counselor when my accommodations no longer meet my access needs or need modifying.

 I must provide ample notification of requested accommodations to my professors and/or service

providers and work collaboratively by discussing my access needs.

 I understand the following responsibilities for accessing accommodations:

* Requesting an accommodation letter each semester/term;
* Notifying my professors which accommodations will be utilized; and
* Submitting timely requests for accommodation services to the Student Counseling and Advising Service accommodation office.

 I understand I am prohibited from sharing course materials obtained through accommodations.

 I understand that if my program includes a practicum, internship, or pre/clinical experience that the

accommodation may not be applicable, and it is my responsibility to inform and discuss with my academic advisor and/or dean of the school or college of my major.

**Authorization for Use/Disclosure of Information:**

 I voluntarily consent to authorize the **SCAS/ADA OFFICE** to use or disclose the information

 contained in my file during the term of this Authorization

 I voluntarily consent and authorize the SCAS & ADA Office to use, disclose or release information

 solely for the purposes of reporting data as deem necessary by the University of Guam.

**Term:** I understand that this *Authorization* will remain in effect:

/ / From the date of this Authorization until I graduate from the University of Guam.

/ / Until withdrawn by myself or any authorized representative.

If you have any questions regarding these policies, please contact the Student Counseling and Advising Services Accommodations Services prior to signing this release form.

**NOTE:**

**This Authorization extends only to information and documents submitted to the SCAS/ADA** **Office and contained in my case file.**

Student Name (Print) Student Signature Date

(Print) Student Signature Date

(Parent/Guardian of student under 18 years of age)