Application for Accommodations Checklist

STUDENT: Please complete the following steps to apply for accommodations at Holy Family University.

_____ Fill out Part 1 - Student Information Intake Form

_____ Fill out Part 2 - Student Questionnaire

_____ Fill out Part 3 - Release of Information

_____ Have Provider fill out Part 4 - Verification of Disability form

_____ Contact Disability Services office at Holy Family University to set up appointment to meet with Disability Services Coordinator to turn in packet. Please note, entire packet needs to be submitted for the Disability Eligibility Committee to review.

Questions? Please contact the Disability Services Office.

Erin G. Leuthold, MS Ed
Disability Services Coordinator
Holy Family University
9801 Frankford Avenue, Campus Center – Room 213
Philadelphia, PA 19114-2094
P - 267-341-3231
F – 267-341-3581
eleuthold@holyfamily.edu

For office use
Date submitted –
DS initials -

EL 5/2015
Office of Disability Services

Part 1 - Student Information Intake Form

STUDENT: Please fill out the following information.

Name: _________________________________    Date: ________________

Address: _______________________________________________________________________

If applicable, on-campus address: _________________________________________________

Email: (Holy Family email preferred) _______________________________________________

Phone:    Home: _______________________    Cell: _______________________

Academic Status:   Not yet registered   FR     SO     JR     SR    GRAD   CERT     ACCEL

Major: ____________________________    Advisor: _________________________________

Transfer Student? Y___ N___
If yes, name & date of college(s) and/or university(ies):

Status:
Full-time student_____ Part-time student_____ Summer Study___ Certification_____ 

Were you referred to the Disability Office? Y ___   N ___
If yes, by whom? _____________________________________________________________

Have you previously received accommodations at Holy Family University? Y ___   N___
If yes, when? (Please circle): Spring    Fall    Summer    Year: ________________

Describe accommodations/academic adjustments you are requesting:

Professionals from whom we will be receiving documentation:
Office of Disability Services

Part 2 - Student Questionnaire

STUDENT: Please fill out the following questions to the best of your ability.

Name ________________________________________________________

Please describe your diagnosis/disability:

How do you learn best in academic settings and in daily life?

List accommodations, including assistive technology or adaptive equipment, used in the past and whether or not they were helpful:

Please provide any additional information you would like us to know in considering your request:
In Support of my request for reasonable accommodations, I have provided the Disability Services Office at Holy Family University with documentation of my disability. By signing this Release form, I __________________________ (Students name) authorize the Disability Services Office at Holy Family University to release this information to the members of the Disability Eligibility Committee of Holy Family University for evaluation purposes.

__________________________________________
Student Signature Date

__________________________________________
Coordinator of Disability Services Signature Date
Office of Disability Services

Part 4 - Verification of Disability

PROVIDER: Please fill out the following information for your client, ________________, and attach the appropriate supplemental documentation. Thank you in advance for your support and cooperation in this matter.

Please note, Holy Family University provides reasonable accommodations to otherwise qualified students with a documented disability* in accordance with the Americans with Disabilities Act of 1990 (ADA), the ADA Amendment Act of 2008 and Section 504 of the Rehabilitation Act of 1973. Final determination of granted accommodations will be decided by the Eligibility Committee of Disability Services at Holy Family University.

Practitioner Name/Title ____________________________ Date ________________

Address ______________________________________________________________________

Telephone _________________________ Fax ______________________________

License or Certification number ________________________________________________

Specialty/qualification to make diagnosis _______________________________________

Date of last appointment ________________________________

1. Diagnosis, date of diagnosis and date of last contact with student. Please include expected duration.

2. Describe the symptoms associated with the condition.

3. Severity of condition.

   _____ Mild          _____ Moderate          _____ Severe

*Note: A documented disability refers to a disability that substantially limits one or more major life activities.
4. List current medication(s), dosage frequency and adverse side effects.

5. Check all relevant functional limitations that are substantially limited.

- Walking
- Hearing
- Seeing
- Working
- Sleeping
- Caring for self
- Learning
- Standing
- Lifting
- Bending
- Breathing
- Reading
- Thinking
- Working
- Concentrating
- Communicating
- Interacting with others
- Performing manual tasks
- Other, please describe ________________

6. Please explain how each functional limitation will specifically affect your client in the higher education environment.

7. Please suggest reasonable accommodations for your client. Each recommendation must be supported by the diagnosis. Please discuss the rationale for each suggested accommodation relating it to a specific functional limitation.

8. Please state alternatives to meet the documented need if the first request cannot be met.
9. Please discuss the impact on your client’s disability if the accommodation cannot be granted.

10. Additional comments:
Taken from the ADA Amendments Act of 2008, this document is available at http://www.eeoc.gov/laws/statutes/adaaa.cfm

* DEFINITION OF DISABILITY.—Section 3 of the Americans with Disabilities Act of 1990 (42 U.S.C. 12102) is amended to read as follows:

“SEC. 3. DEFINITION OF DISABILITY.

“As used in this Act:

“(1) DISABILITY.—The term ‘disability’ means, with respect to an individual—

“(A) a physical or mental impairment that substantially limits one or more major life activities of such individual;

“(B) a record of such an impairment; or

“(C) being regarded as having such an impairment (as described in paragraph (3)).

“(2) MAJOR LIFE ACTIVITIES.—

“(A) IN GENERAL.—For purposes of paragraph (1), major life activities include, but are not limited to, caring for oneself, performing manual tasks, seeing, hearing, eating, sleeping, walking, standing, lifting, bending, speaking, breathing, learning, reading, concentrating, thinking, communicating, and working.

“(B) MAJOR BODILY FUNCTIONS.—For purposes of paragraph (1), a major life activity also includes the operation of a major bodily function, including but not limited to, functions of the immune system, normal cell growth, digestive, bowel, bladder, neurological, brain, respiratory, circulatory, endocrine, and reproductive functions.

Signature of Provider

Date