



SAN JOAQUIN DELTA COLLEGE
DISABILITY SUPPORT PROGRAMS & SERVICES (DSPS)
DERICCO BUILDING, ROOM 234
5151 PACIFIC AVENUE, STOCKTON, CA 95207
PHONE: (209) 954-5151, EXT. 6272 ▪ FAX: (209) 954-3758

APPLICATION FOR SERVICES

By completing this application for services student will:

1. Provide DSPS with the information, documentation and/or forms (medical, educational, etc.) deemed necessary to verify disability.
2. Meet with a DSPS counselor to complete a **Student Educational Contract** and then meet with the counselor once each semester to update the **DSPS Accommodations Notice**.
3. Make measureable progress towards the goals established in the Student Educational Contract and meet academic standards established by San Joaquin Delta College.
4. Comply with the **Student Code of Conduct** located in the SJDC Student Handbook and college website:
<http://www.deltacollege.edu>.

STUDENT INFORMATION

Date of Application: _____ ☐ Summer ☐ Fall ☐ Spring Academic Year: _____
Name: _____ SSN/ID: _____
Address: _____ City: _____ Zip: _____
Phone : _____ DOB: _____
Email: _____ Maiden name/other name used: _____

The following questions are designed to help us evaluate your needs for reasonable accommodations. Verification of disability must be on file in order to receive DSPS services.

1. Are you currently a client of any of the following agencies?

- | | | |
|---|------------------------------|-----------------------------|
| a. Department of Rehabilitation | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| If yes, Name of counselor: _____ | | |
| b. County Behavioral Health | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| c. Regional Center for Developmental Disabilities | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| d. Vocational Rehabilitation | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

2. What are your educational goals? (Check all that apply):

- | | | | |
|---|---------------------------------------|--------------------------------------|---|
| <input type="checkbox"/> Associate Degree (AA/AS) | <input type="checkbox"/> Basic Skills | <input type="checkbox"/> Certificate | <input type="checkbox"/> Transfer to 4-year |
| <input type="checkbox"/> Undecided | What is your major? _____ | | |

3. How would you describe your disability?

- | | | |
|---|---|---|
| <input type="checkbox"/> Brain Injury | <input type="checkbox"/> Communication Disability | <input type="checkbox"/> Developmental Disability |
| <input type="checkbox"/> Learning Disability | <input type="checkbox"/> Physical Disability | <input type="checkbox"/> Psychological Disability |
| <input type="checkbox"/> Other (please describe): _____ | | |

4. What educational difficulties do you experience because of your disability?

5. Are you taking any medication(s) that affects your learning process? ☐ Yes ☐ No
List medication(s) and adverse effect(s): _____

6. What type of service(s) or support are you requesting?

7. Have you received educational accommodations in the past? ☐ Yes ☐ No
If yes, indicate setting: ☐ K – 12 ☐ Community College ☐ University

8. What type of educational assistance/accommodations have you received in the past?

9. Are you receiving services/assistance from:

a. Cal WORKS	<input type="checkbox"/> Yes	<input type="checkbox"/> No
b. Extended Opportunity Programs and Services (EOPS)	<input type="checkbox"/> Yes	<input type="checkbox"/> No
c. Financial Aid / Scholarship	<input type="checkbox"/> Yes	<input type="checkbox"/> No
d. SSI / SSDI	<input type="checkbox"/> Yes	<input type="checkbox"/> No
e. Veteran's Administration	<input type="checkbox"/> Yes	<input type="checkbox"/> No

I understand that I must fulfill the requirements for participation in the DSPS Program. I have received a copy of the policy on suspension of DSPS services, and I understand the consequences of failing to comply with the rules for responsible use of DSPS services. I understand that I will be notified in writing before any action is taken to suspend services. By signing this application, I affirm that I understand and agree with the DSPS Program responsibilities of students and I will abide by them.

Student Signature: _____ **Date:** _____

Signature of Parent/Guardian: _____ **Date:** _____
(Required for students under 18 years of age)

FOR OFFICE USE

I hereby certify this student is eligible for DSPS services based on:

- ☐ Review of documentation provided by appropriate agencies or certified licensed Professional.
- ☐ Observation by DSPS counselor.

Primary Disability: _____ Secondary Disability: _____

DSPS Counselor Signature: _____ Date: _____

SLO Assessment:

Student is able to:	Yes	Somewhat	No
1. Identify disability(ies)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. State educational limitations	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Articulate needed accommodations	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Notes: _____
