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 ☐ Yes ☐ No
      If yes, Name of counselor: _____
   b. County Behavioral Health ☐ Yes ☐ No
   c. Regional Center for Developmental Disabilities ☐ Yes ☐ No
   d. Vocational Rehabilitation ☐ Yes ☐ No

2. What are your educational goals? (Check all that apply):
   ☐ Associate Degree (AA/AS) ☐ Basic Skills ☐ Certificate ☐ Transfer to 4-year
   ☐ Undecided What is your major? _____

3. How would you describe your disability?
   ☐ Brain Injury ☐ Communication Disability ☐ Developmental Disability
   ☐ Learning Disability ☐ Physical Disability ☐ Psychological Disability
   ☐ 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	☐ Yes	☐ No
b.	Extended Opportunity Programs and Services (EOPS)	☐ Yes	☐ No
c.	Financial Aid / Scholarship	☐ Yes	☐ No
d.	SSI / SSDI	☐ Yes	☐ No
e.	Veteran's Administration	☐ Yes	☐ 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)	☐	☐	☐
2. State educational limitations	☐	☐	☐
3. Articulate needed accommodations	☐	☐	☐

Notes: _____

_____

San Joaquin Delta College
Disability Support Programs & Services (DSPS)
DeRicco Student Support Services Building, Room 234
5151 Pacific Avenue, Stockton CA 95207
Phone: (209) 954 - 5151, EXT.6272 ▪ Fax: (209) 954 - 3758

CONSENT FOR RELEASE OF INFORMATION

Name: _____ SSN/ID: _____

Address: _____ City, Zip _____

Phone: _____ DOB: _____

Maiden name/other name used: _____

In order to receive disability related services at San Joaquin Delta College, a verification of disability must be provided. I hereby authorize the treating professional named below to complete a Confidential Disability Verification Form to include one or more of the following records identified below.

Check one:

- ❑ Audiology and speech/language pathology reports
- ❑ Educational records, including progress made
- ❑ Learning disability assessment
- ❑ Psychological testing and evaluation results
- ❑ Verification of disability
- ❑ Vocational rehabilitation plan
- ❑ Other: _____

Name of Licensed or Certified Professional: _____

Affiliated Organization/Agency: _____

Address: _____ *City, Zip:* _____

Phone: _____ *Fax:* _____

Email: _____

I understand that this information will be kept confidential and will be used only in providing reasonable academic accommodations.

Student Signature: _____ ***Date:*** _____

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

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CONFIDENTIAL DISABILITY VERIFICATION

TO BE COMPLETED BY STUDENT ***Note: Documentation will be shred for students who do not complete the DSPS intake process within a calendar year. Should the student return, new disability verification must be submitted.***

LAST: _____FIRST:_____

ADDRESS: _____CITY: _____ZIP: _____

BIRTH DATE: _____ SSN/ID#:_____TELEPHONE:_____

TO BE COMPLETED BY CERTIFIED/LICENSED PROFESSIONAL

PROVIDER NAME (Print): _____ TITLE: _____

ADDRESS: _____ CITY: _____ZIP: _____

TELEPHONE: _____FAX: _____

Please provide the following information in full in order to help determine reasonable educational and physical accommodations to support this student:

1. **Diagnosis:** _____ **Date of Diagnosis:** _____

If Applicable:

DSM-IV-TR Code: _____ Severity: ☐ Moderate ☐ Severe ☐ Residual/Remission

In order to provide services, we must have:

- ❍ A verification of a psychological disability that is coded on Axis I or Axis II as moderate to severe and
- ❍ A Global Assessment of Functioning (GAF) score of 60 or below.

Axis I: _____ Axis II: _____Axis III: _____
Axis IV: _____ Axis V: _____GAF Score: _____

List current medication(s), impact, and adverse side effects:

Medication: _____Impact: _____
Side effects experienced by patient: _____

Level of hearing loss: (Indicate appropriate description (s) ☐ Mild ☐ Moderate ☐ Severe ☐ Profound

- ❍ Uses aided hearing.
- ❍ Hearing loss interferes with client's learning.
- ❍ Would benefit from amplification devices in an educational/vocational setting.

Visual impairment - I certify this client to be visually impaired according to the following criteria:

- ❍ A visual acuity of 6/21 (20/70) or less in the better eye after correction.
- ❍ A visual field of 20 degrees or less in the better eye after correction.
- ❍ Any progressive eye disease with a prognosis of becoming one of the above in the next two years.
- ❍ An uncorrectable vision problem or reduced visual stamina such that the applicants functions throughout the day as if his/her visual acuity is limited to 6/21 or less in the better eye after correction.

2. **Is the student/patient currently under your care?** ☐ Yes ☐ No

3. **This condition substantially limits one or more of the following major life activities: (required)**

☐ Bending ☐ Breathing ☐ Caring for self ☐ Communicating ☐ Concentrating/Learning
☐ Eating ☐ Hearing ☐ Lifting ☐ Moving ☐ Performing manual tasks
☐ Reading ☐ Seeing ☐ Speaking ☐ Standing ☐ Walking
☐ Other: _____

_____

4. **Condition is:** ☐ Prone to Exacerbation ☐ Stable

5. **Does it impact any of the following?** (Optional) ☐ Forming/Executing Plans ☐ Overcoming Obstacles
☐ Memory ☐ Social Interaction

6. **Duration of disability:** ☐ Permanent/Chronic ☐ Temporary until _____
☐ If temporary (select one) ☐ Less than 45 days ☐ 45 days or greater
Expected duration: _____

7. **Describe the student's daily functional limitations in an educational setting and/or any recommended device(s):**

_____

_____

_____

8. **Please provide any additional information/comments helpful in determining accommodations in an educational setting:**

_____

_____

_____

Educational, medical, and/or psychological documentation should be attached and returned to:

☐ **College:** San Joaquin Delta College
Disabled Student Programs and Services
5151 Pacific Avenue
DeRicco Student Services Building, Room 234
Stockton, CA 95207

☐ **Email:** sss-faxes@deltacollege.edu

☐ **Fax:** (209) 954-3758

The information provided by you regarding the above-named student will be treated as confidential and will be disclosed by the College only as necessary for assessment and/or implementation of the requested services or accommodations.

Verifying Professional Signature License/Certification Number Date