



U of SC Aiken

Disability Services

Dear Student:

You recently contacted our office regarding information about Disability Services. If you have a diagnosed physical, psychological, and/or learning disability, you may qualify for services that can facilitate your access to the educational programs and services at USCA. To place your information on file with the Office of Disability Services, you will need to complete all of the forms in the Disability Services packet, provide us with an evaluation from a qualified professional, and meet with our coordinator after the materials are reviewed.

Once all documentation has been submitted, you will be contacted by our office for an appointment to discuss your appropriate accommodations. Please return the completed forms to:

Office of Disability Services
University of South Carolina Aiken
471 University Parkway, Box 15
Aiken, SC 29801
Fax (803) 641-3677
Disabilityservices@usca.edu

If you have any questions, please contact our office by calling (803) 643-6815. We look forward to assisting you!

Sincerely,

Sandra Robinson, M.C.C.
Disability Services Coordinator



U of SC Aiken

Disability Services

Registration Checklist

Getting Started:

- ____1) To request services, contact USCA Disability Services once you are admitted. There is a sheet in your Admissions Package that you may complete and return to us requesting information, or you may call us at 803-643-6815.
- ____2) Once you receive the Disability Services Registration packet, read and complete all forms. Return forms to Disability Services, 471 University Parkway, Box 15, Aiken, SC 29801.

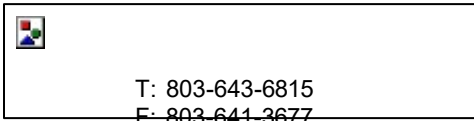
Documentation:

- ____3) Provide Disability Services with appropriate documentation that includes a statement of diagnosis and suggested accommodations. Documentation must be provided by a qualified health professional such as a physician, psychologist, psychiatrist, or neuropsychologist.
- ____4) If you do not have a copy of your documentation, contact your health professional and ask that your documentation be sent to the following address:

University of South Carolina Aiken
Disability Services
471 University Parkway, Box 15
Aiken, SC 29801
- ____5) Follow up with your health professional to make sure they have forwarded your documentation to Disability Services.
- ____6) Follow up with Disability Services to make sure documentation has been received.

Appointment:

- ____7) Schedule an initial appointment with the Disability Services Coordinator to discuss your documentation and accommodation sheets.



Today's date: _____

Confidential Client Registration

Name: Last _____ First _____ Preferred Name _____ Middle initial _____

USC or VIP ID _____ USCA email: _____

Date of Birth ____ / ____ / ____

Cell phone _____ Home phone _____

Local address _____ Apt: _____

City: _____ State: _____ Zip: _____

Permanent address _____ Apt: _____

City: _____ State: _____ Zip: _____

Emergency contact _____ Phone _____

What is the best way to contact you? _____

A. PERSONAL INFORMATION

Age _____

Sex

____ Female
____ Male

Referred by

____ Self
____ Admissions counselor
____ Friend
____ Faculty/staff
____ Student peer group
____ Housing staff
____ Coach/athletic staff
____ Parent or guardian
____ Student Health Center/health professional
____ Other _____

Ethnicity

____ African American
____ Asian American
____ Euro-American (Caucasian)
____ Hispanic American
____ Multi-Racial (Bi-racial)
____ Native American
____ Other _____

Classification

____ Freshman
____ Sophomore
____ Junior
____ Senior
____ Graduate student
____ Other _____

Transfer student _____ Yes _____ No

Have you received services before? _____ Yes _____ No

If yes, specify date(s) and school(s) _____

If relevant to the present problem, may we contact the Disabilities Services professional at those schools?
____ Yes _____ No

USCA enrollment

____ Full-time _____ Part-time Major _____ Current GPA _____

Degree objective _____ Advisor _____

Initial enrollment date/expected enrollment date _____ Expected graduation date _____

B. MEDICAL INFORMATION

What type of disability do you have?

Please list/describe:

Date(s) of onset and/or diagnosis:

- (1) _____ (1) _____
- (2) _____ (2) _____
- (3) _____ (3) _____

Current medications _____

Medical restrictions: _____

Are you a client of Vocational Rehabilitation Services?_Yes No

If yes, in which county?_____Counselor's name/phone _____

C. ACCOMMODATIONS

Selection does not imply approval by the DS Office. Selection indicates only which services you are interested in or would like more information about. All accommodations must be approved by the DS Office based on documentation.

CLASSROOM ACCOMMODATIONS:

- _____ Audio record lectures
- _____ Accessible desk and/or chair
- _____ Front row seating
- _____ Allow opportunity to make up missed exams/ assignments due to disability with medical documentation
- _____ Adaptive/assistive technology
- _____ Additional absences and/or extensions with medical documentation
- _____ Large-print handouts
- _____ Braille handouts
- _____ Verbal description of visual aid
- _____ Sign language services
- _____ Assistive listening device
- _____ Other _____

TESTING ACCOMMODATIONS:

- _____ Extended testing time
- _____ Low-distraction testing location
- _____ Oral tests
- _____ Reader
- _____ Scribe
- _____ Large -print tests
- _____ Braille tests
- _____ Voice calculator
- _____ Use of computer for essay tests
- _____ Other _____

GENERAL ACCOMMODATIONS:

- _____ Tutoring services
- _____ Counseling referral
- _____ Support group information
- _____ Alternative media formats
- _____ Course modification/substitution
- _____ Reduced course load
- _____ Wheelchair access
- _____ Disability parking information
- _____ Accessible field trip transportation
- _____ Orientation/mobility
- _____ Adaptive/assistive technology
- _____ Adaptations to housing
- _____ Additional health care needs
- _____ Other _____

How does your disability currently impact your functioning, and how does it cause you substantial limitation in the academic setting? _____

Signature _____

Date _____

STUDENT RESPONSIBILITY STATEMENT

Application for Services

- ◆ I understand that, as a college student with a disability who is requesting services, I am obligated to provide notification of my disability to the USC Aiken Office of Disability Services.
- ◆ I further realize that in order to receive services, the Office of Disability Services must receive my completed application materials and a written evaluation from a qualified professional that demonstrates the existence of my disability.
- ◆ The Office of Disability Services will review my documentation to determine my eligibility for services. After my eligibility for services has been verified, I must meet with a representative of the Office of Disability Services to discuss the services and/ or accommodations that are appropriate for me. During this meeting, I will have an opportunity to aid in the identification of individual services to accommodate my disability. Completion of this meeting is the final step before commencement of services.

Enrollment in Services

- ◆ Appropriate services will then be implemented on a continuous basis each semester that I am enrolled at USC Aiken.
- ◆ Letters regarding my educational accommodations must be picked up each semester and given to my advisor and my professors/instructors to notify them of my needs. As such, I understand that any disclosure of information about my disability will be limited to what is minimally necessary to coordinate my educational accommodations.
- ◆ Once I have received my accommodation forms, I recognize that I should make an appointment with any professors/ instructors with whom I will have to coordinate my services, e.g., note-taking assistance or special testing accommodations. If the professor and I determine that the Office of Disability Services will need to help in the administration of any tests, it is my responsibility to contact Disability Services and provide that office with a copy of my syllabus so that they can assist me in making arrangements for testing proctors.
- ◆ If special classroom or testing accommodations have been made that involve the services of others, then I must notify the Office of Disability Services in advance of any inability to attend classes, (e.g., readers, sign language interpreters, or proctors for special testing arrangements). I understand that if I fail to comply with this notification requirement, these services may be temporarily withheld.
- ◆ I further understand that it is my responsibility to notify the Office of Disability Services of any problems or difficulties with my accommodations.
- ◆ I also understand that it is my responsibility to update the office as necessary regarding the need for additional services. The Office of Disability Services will review all new requests for services and implement additional services as deemed appropriate.
- ◆ If I am not enrolled for two consecutive semesters, i.e., fall and spring, I will need to notify the Office of Disability Services to reactivate services once I resume classes at USC Aiken.

Finally, I understand that I have a right to file a formal grievance with the Americans with Disabilities Act (ADA) Compliance Office, Room 116 – Penland Administration Building, USC Aiken, 471 University Parkway, Aiken, SC 29801, regarding any unresolvable dispute with the Office of Disability Services related to my disability.

RECEIPT OF STUDENT RESPONSIBILITY STATEMENT

I have received a copy of the Student Responsibility Statement from the Office of Disability Services and agree to review its contents. During my enrollment at USC Aiken, I will use this document as a reference to assist me in understanding my responsibilities as a student with a disability at USC Aiken. If the Office of Disability Services makes any additions or amendments to the Student Responsibility Statement, I understand that the Office will make reasonable efforts to inform me of these changes. If I am unclear about any existing policy, I understand that it is my responsibility to direct my questions to:

Office of Disability Services
University of South Carolina Aiken
471 University Parkway, Box 15
Student and Educational Support
Building Room 104/105
Aiken, SC 29801
(803) 643-6815

Student's Signature: _____

Date: _____

RELEASE OF INFORMATION TO FACULTY/STAFF/SERVICE PROVIDER

I hereby authorize the staff of the Office of Disability Services at the University of South Carolina Aiken to release any pertinent medical, psychological, educational, or vocational information to the faculty and staff at the University of South Carolina Aiken and/or other providers of supporting services. This disclosure is to assist me in fully participating in an educational activity. Disclosure of information will be restricted to what is necessary, relevant, and verifiable.

If you would like to give us permission to speak with an additional contact person (e.g., a family member) regarding certain designated information, please provide the name of the person, their telephone number, and the nature of the information you are permitting to be released/discussed:

Name of Person _____

Relationship _____ Telephone _____

Nature of Information:

_____ Specific accommodations, e.g. books on tape

_____ Documentation of disability

_____ Information related to services I receive through the Office of
Disability Services

_____ Other _____

I understand that I have a right to revoke or change this authorization at any time by giving written notification to the Office of Disability Services, University of South Carolina Aiken, 471 University Parkway, Box 15, Student and Educational Support Building, Room 104-105, 471 University Parkway, Aiken, SC 29841.

Student's Name (print) _____

Signature _____ Date _____

Witness signature _____ Date _____



AUTHORIZATION FOR REQUEST/RELEASE OF CONFIDENTIAL INFORMATION

I, _____, whose Date of Birth is _____,
authorize University of South Carolina Aiken Office of Disability Services to disclose to and/or obtain from _____
_____ the following information:

Description of Information to be disclosed/obtained: **(Please initial each item to be disclosed)**

- | | |
|-------------------------------|--------------------------------|
| _____ Assessment | _____ Medical Information |
| _____ Diagnosis | _____ Psychosocial Evaluation |
| _____ Educational Information | _____ Psychological Evaluation |
| _____ Psychiatric Evaluation | _____ Other _____ |

Purpose

The purpose of this disclosure of information is to provide/obtain documentation of eligibility for Disability Services

If other purpose, please specify: _____

Revocation

I understand that I have a right to revoke this authorization, in writing, at any time by sending written notification to University of South Carolina Aiken Office of Disability Services at 471 University Parkway, Box 15, Aiken, South Carolina 29801. I further understand that a revocation of the authorization is not effective to the extent that action has been taken in reliance on the authorization.

Expiration

Unless sooner revoked, this consent expires on the following date: _____ or as otherwise indicated: _____.

Form of Disclosure

Unless you have specifically requested in writing that the disclosure be made in a certain format, we reserve the right to disclose information as permitted by this authorization in any manner that we deem to be appropriate and consistent with applicable law, including, but not limited to, verbally, in paper format or electronically.

Disclosure

Federal law prohibits the person or organization to whom disclosure is made from making any further disclosure of treatment information unless further disclosure is expressly permitted by the written authorization of the person to whom it pertains or as otherwise permitted. The recipient of the information in the following circumstances may disclose other types of information: _____

Signature of Student Date

Signature of Parent, Guardian or Personal Representative Date

If you are signing as a Personal Representative of an individual, please describe your authority to act for this individual (e.g., power of attorney, healthcare surrogate, etc.) _____

Signature of Witness Date