CUA

The Catholic University of America
Office of Disability Support Services
620 Michigan Ave NE, 201 Pryzbyla Center
Washington, DC 20064
Phone 202-319-5211, Fax 202-319-5126

Dear Prospective Student,

In order to establish eligibility for services and to enable our staff to work more effectively with you in the provision of services, please complete the enclosed Intake form and provide documentation of the disability as outlined by our Documentation Guidelines. All records will remain strictly confidential and are not a part of your academic record.

The aforementioned guidelines are provided so that Disability Support Services can respond appropriately to the individual needs of the student. We reserve the right to determine eligibility for services and modifications to programs based on the quality of the submitted documentation. All documentation is confidential.

CONFIDENTIALITY

The University recognizes that student disability records contain confidential information and are to be treated as such. Therefore, documentation of a student's disability is maintained in a confidential file in DSS and is considered part of the student's education record. Information related to a disability may be disclosed only with the permission of the student or as permitted by the university's student records policy and federal law. At the same time, however, a student's right to privacy must still be balanced against the university's need to know the information in order to provide requested and recommended services and accommodations. Therefore, in the interest of serving the needs of the student, the provision of services may involve DSS staff disclosing disability information provided by the student to appropriate University personnel participating in the accommodation process. The amount of information that may be released is determined on a case-by-case basis, and will be made in accordance with the university's policy on student records.

I have read and understand the above policies and agree with the terms. Sign your name indicating you composed and wrote the responses to the questions in the form.

Signature: _____

Name (Print): _____ Date: _____

All forms must be returned directly to:

Disability Support Services
The Catholic University of America
620 Michigan Ave NE, 201 Pryzbyla center
Washington, DC 20064
Phone: 202-319-5211 Fax: 202-319-5126
Email: cua-disabilityservices@cua.edu

IT IS STRONGLY RECOMMENDED THAT ALL FORMS AND DOCUMENTATION BE RETURNED BEFORE THE START OF THE SEMESTER IN ORDER TO ALLOW TIME FOR PROCESSING.

OFFICE USE ONLY

_____ Date Registration Form Received

_____ Date Intake Completed _____ By (INT)

_____ Date Documentation Received

_____ Date Additional Documentation Received

_____ Date Documentation Approved

Updated: 4/10/13

DISABILITY SUPPORT SERVICES
GRADUATE REGISTRATION FORM

In order to receive accommodations, please submit a copy of your documentation regarding your disability with this form. Documentation guidelines are available at http://dss.cua.edu. Documentation must be received before your registration is complete.

Date: _____

I BIOGRAPHICAL INFORMATION

Name: _____

First *Middle* *Last*

Student ID # _____ Birth Date: _____ Gender: MALE FEMALE

Race/Ethnic Background (Optional): _____ Military Active or Veteran: ☐ Yes ☐ No

Cell Phone: _____ Home Phone: _____

Other Phone: _____

Address:

_____

_____

City *State* *Zip Code*

CUA E-mail Address: _____@cardinalmail.cua.edu

Alternate E-mail Address: _____

II STUDENT STATUS

First Semester at CUA: Fall Spring Summer Year: _____

Anticipated Date of Graduation: Fall Spring Year: _____

Year in program: 1st 2nd 3rd 4th

Please indicate your anticipated degree: ___ MA PhD ____ Other_____

School/Program:

___ Arts & Sciences: Area: _____

___ Architecture ___ Music ___ Theology ___ Business & Economics

___ Engineering ___ NCSSS ___ Philosophy ___ Library & Information Sciences

___ Law Metropolitan College of Professional Studies Nursing

III DISABILITY INFORMATION

Disability (check all that apply):

____ ADD or ADHD Type: _____ Date/Age at Diagnosis: _____

____ Learning Disability: Type: _____ Date/Age at Diagnosis: _____

____ Autism Spectrum: Type: _____ Date/Age at Diagnosis: _____

____ Blind or Low Vision* Date/Age at Diagnosis: _____

____ Deaf or Hard of Hearing* Date/Age at Diagnosis: _____

____ Health Type: _____ Date/Age at Diagnosis: _____

____ Mobility* Type: _____ Date/Age at Diagnosis: _____

____ Psychological Type: _____ Date/Age at Diagnosis: _____

____ Traumatic/Acquired Brain Injury Date/Age at Diagnosis: _____

____ Other: _____ Date/Age at Diagnosis: _____

*Please complete the additional sections below

Mobility (Skip if this section does not apply to you)

Level of Mobility:

- Dexterity: ___ All ___ None ___ Limited
- Ambulatory: ___Yes ___ No ___ With minimal assistance

Do you require a personal care attendant? ___ Yes ___ No

Do you use a service animal? ___ Yes ___ No

Mobility Device Requirements:

___ Electric Wheelchair ___ Manual Wheelchair ___ Scooter

___ Other (Walker, crutches, cane, etc.)

Blind & Low Vision (Skip if this section does not apply to you)

Level of Disability

___ Total Blindness

___ Legally Blind

___ Low Vision

___ Partial vision with glasses

Do you use a Seeing Eye dog? ___ Yes ___ No

Deaf & Hard of Hearing (Skip if this section does not apply to you)

Level of Disability

___ Completely Deaf

___ Have some hearing (with aides)

___ Have some hearing (without aides)

___ Have hearing in one ear

___ Can read lips

Supports

___ Hearing Aids

___ Assistive Listening Device (FM System)

___ Interpreter (ASL)

___ Transcriber (CART)

Do you use a hearing dog? ___ Yes ___ No

Please list any **disability** related medications you are taking:

Name: _____Purpose: _____Start date: _____Dosage: _____
Name: _____Purpose: _____Start date: _____Dosage: _____
Name: _____Purpose: _____Start date: _____Dosage: _____
Name: _____Purpose: _____Start date: _____Dosage: _____

Please explain how the medication helps you:

_____

_____

_____

IV SERVICE HISTORY

If you received services at a previous institution please describe:

High School:

What was the size of your school? ___ Small ___ Medium ___ Large

Was it a school that specialized in working with students with learning disabilities? ___ Yes ___ No

Did it have Special Education/Support Services? ___ Yes ___ No

Did you use your accommodations? ___ Yes ___ No

College/University:

Name of the school: _____

City and State: _____

Dates Attended: _____

Reason for Leaving: _____

Did you request accommodations at this institution? YES NO

Were accommodations provided? YES NO

How have services you have received previously assisted you?

_____

_____

_____

For students who receive agency services: (Skip if this section does not apply to you)

Do you currently receive assistance from any of the following?

_ Services for the Blind ___ Department of Rehabilitation Services ___ Department of Veteran Affairs

___ Other: _____

Name of Rehab Counselor: _____ Email: _____

Agency Name: _____

V CURRENT IMPACT STATEMENT

Functional Limitations: Please check off the activities listed below that you believe are affected as a result of your diagnosis. Please indicate level of limitation you experience as a result of the disability.

1= Unable to Determine 2= No Impact 3= Mild Impact 4= Moderate Impact 5= Substantial Impact

1	2	3	4	5	Major Life Activities		1	2	3	4	5	Learning / Time Management
					Caring for Oneself							Memory
					Talking							Concentrating
					Hearing							Listening
					Breathing							Organization
					Seeing							Managing distractions
					Walking							Timely submission of assignments
					Standing							Attending class regularly
					Lifting/Carrying							Making and keeping appointments
					Sitting							Managing stress
					Performing Manual tasks							Reading
					Eating							Writing
					Working							Spelling
					Interacting with others							Quantitative reasoning (math)
					Sleeping							Processing Speed

Describe in as much detail as possible how the diagnosed condition is currently impacting you (use additional paper if necessary).

_____

_____

_____

_____

_____

Describe in as much detail as possible how the diagnosed condition has or has not impacted and substantially limited you in the past. Describe what supports you have used? (use additional paper if necessary).

_____

_____

_____

_____

_____

If you have tried any medical or educational interventions to manage the diagnosed condition, please explain what these were and how and why they have or haven't helped (use additional paper if necessary).

_____

_____

_____

_____

_____

ACADEMIC ACCOMMODATIONS RECEIVED/REQUESTING

Please check/describe any services you have received in the past under “Previously Received”.
Please check those services you are interested in requesting at CUA under “Requesting at CUA”.

	Received in High school	Received in college	Requesting at CUA
Classroom Accommodations:			
Access to teacher handouts, slides, overheads	☐	☐	☐
Additional time on in-class writing assignments	☐	☐	☐
Assistive Listening Device (FM Loop)	☐	☐	☐
Assistive Technology (laptop, note taking device, etc.)	☐	☐	☐
Closed Caption Video	☐	☐	☐
Information on board read aloud for students with visual impairments	☐	☐	☐
Interpreter/Transcriber:	☐	☐	☐
ASL	☐	☐	☐
CART	☐	☐	☐
C-PRINT	☐	☐	☐
TYPEWELL	☐	☐	☐
Leave classroom when symptoms occur	☐	☐	☐
Notetaker	☐	☐	☐
Occasional exceptions to absentee/tardiness policy	☐	☐	☐
Recorded Lectures/ Smartpen	☐	☐	☐
Foreign Language Waiver or Substitution	☐	☐	☐
Test Accommodations:			
Additional time when taking quizzes and exams (1.5 or 2)	☐	☐	☐
Alternate exam dates during heavy scheduling/space between	☐	☐	☐
Alternative testing environment	☐	☐	☐
Assistive Technology on exams	☐	☐	☐
Screen Reading Software	☐	☐	☐
Voice Input Software	☐	☐	☐
Other	☐	☐	☐
Calculator	☐	☐	☐
Computer for tests	☐	☐	☐
No scantron (due to visual issues)	☐	☐	☐
Scribe	☐	☐	☐
Spell-check or points not taken off for spelling	☐	☐	☐
Print Accommodations:			
Materials in Alternative Format	☐	☐	☐
Braille	☐	☐	☐
Electronic (DAISY, MP3, ePub,DOC, KESI, PDF)	☐	☐	☐
Large Print	☐	☐	☐
Services:			
Adjustable Height Table in Class	☐	☐	☐
Priority Registration	☐	☐	☐
Other (please explain):	☐	☐	☐

SERVICES RECEIVED/REQUESTING: (Skip if this section does not apply to you)

	Received in High school	Received in college	Requesting at CUA
Campus Access			
I cannot walk long distances quickly	☐	☐	☐
I cannot walk long distances at all	☐	☐	☐
I cannot go up or down stairs and need access to an elevator	☐	☐	☐
Brailed Room Numbers	☐	☐	☐
Raised Print Room Numbers	☐	☐	☐
I use an assistive walking device that makes it difficult to get around independently during inclement weather	☐	☐	☐
I use a service animal	☐	☐	☐
I use a cane	☐	☐	☐
I will need Orientation & Mobility training	☐	☐	☐
Emergency Evacuation			
Assistance may be required to evacuate a building	☐	☐	☐
Audio/Visual Alarm	☐	☐	☐
Transportation			
I am driving and need access to handicap parking close to my classes	☐	☐	☐
Independent use of the Metro	☐	☐	☐
Para-Transit/Metro Access	☐	☐	☐

OPTIONAL:

If there are additional questions pertaining to my documentation, I give DSS the right to contact the professional who completed the evaluation to obtain further information so that we can appropriately determine eligibility of services.

_____ _____ _____

Signature **Printed Name** **Date**