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
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](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)
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: __________________________________________
**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

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

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

_____________________________________________________________________________________________
_____________________________________________________________________________________________
_____________________________________________________________________________________________
_____________________________________________________________________________________________
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_____________________________________________________________________________________________

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).

_____________________________________________________________________________________________
_____________________________________________________________________________________________
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_____________________________________________________________________________________________
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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”.

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

<table>
<thead>
<tr>
<th>Campus Access</th>
<th>Received in High school</th>
<th>Received in college</th>
<th>Requesting at CUA</th>
</tr>
</thead>
<tbody>
<tr>
<td>I cannot walk long distances quickly</td>
<td></td>
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<td></td>
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<tr>
<td>I cannot walk long distances at all</td>
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<td></td>
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<tr>
<td>I cannot go up or down stairs and need access to an elevator</td>
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<tr>
<td>Brailed Room Numbers</td>
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<tr>
<td>Raised Print Room Numbers</td>
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<tr>
<td>I use an assistive walking device that makes it difficult to get around independently during inclement weather</td>
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<tr>
<td>I use a service animal</td>
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<tr>
<td>I use a cane</td>
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<tr>
<td>I will need Orientation &amp; Mobility training</td>
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</tbody>
</table>

**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