



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 students' 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		

DISABILITY SUPPORT SERVICES UNDERGRADUATE 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: _____ Mark one: ___ Parent's home ___ Mom/Dad Cell

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: _____

___ **Undergraduate Year:** ___ Freshman ___ Sophomore ___ Junior ___ Senior

___ Transfer student

___ Visiting student Dates: _____ to _____

School/Program:

___ Arts & Sciences: Major: _____ or ___ Exploratory

___ Architecture ___ Music ___ Theology ___ Business & Economics

___ Engineering ___ NCSSS ___ Philosophy ___ Library & Information Sciences

___ Nursing ___ Metropolitan College of Professional Studies

III DISABILITY INFORMATION

Disability (check all that apply):

<input type="checkbox"/> ADD or ADHD	Type: _____	Date/Age at Diagnosis: _____
<input type="checkbox"/> Learning Disability:	Type: _____	Date/Age at Diagnosis: _____
<input type="checkbox"/> Autism Spectrum:	Type: _____	Date/Age at Diagnosis: _____
<input type="checkbox"/> Blind or Low Vision*		Date/Age at Diagnosis: _____
<input type="checkbox"/> Deaf or Hard of Hearing*		Date/Age at Diagnosis: _____
<input type="checkbox"/> Health	Type: _____	Date/Age at Diagnosis: _____
<input type="checkbox"/> Mobility*	Type: _____	Date/Age at Diagnosis: _____
<input type="checkbox"/> Psychological	Type: _____	Date/Age at Diagnosis: _____
<input type="checkbox"/> Traumatic/Acquired Brain Injury		Date/Age at Diagnosis: _____
<input type="checkbox"/> 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 or Emotional Support Animal			
I use a cane			
I will need Orientation & Mobility training			
Dining Services			
Assistance Needed (access to food choices help with tray, cutting food, eating)			
My medical condition requires me to be on a special diet			
Other			
Housing Services			
Single Room (for medical issues)			
Accessible Room (elevator, space for chair, equipment, lowered shelves, rods, grab bars, lower peep hole, visual door bell, door handles, etc.)			
Bathroom Modifications (grab bars, roll in, Bathtub, lowered sink)			
Private bath			
Kitchen Modifications-in suites (lowered shelves, roll-under counters, etc.)			
Access to a Kitchen for dietary/health reasons (that cannot be accommodated by consulting with the campus dietician)			
Height of Shelves Adjusted			
Door/Key Modifications			
Accessible Furniture (desk, tables, bed, etc.)			
First Floor Room			
Visual Alarms			
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