Dear Student:

Thank you for inquiring about Disability Services through the Center for Student Success at Ocean County College. In order to establish your eligibility for reasonable accommodations, you must do the following:

1. Complete the enclosed Student Intake Form including the essay.
2. Using the Guidelines for Documentation of Disability, gather and submit documentation of your disability. Copies of medical verification and diagnosis forms A & B are enclosed with this letter.
3. Attend a scheduled Disability Services Information Session held in the Center for Student Success, Library 124. You will receive your Accommodation Plan at this Information Session.

After your completed Student Intake Form and your documentation have been received and reviewed by the Center for Student Success, you will receive a phone call inviting you to a Disability Services Information Session. Students enrolled in all distance learning courses may communicate with Disability Services using phone, fax and email.

To ensure that accommodations are in place at the beginning of the semester, Intake Form, documentation of disability and Disability Services Information Session must be completed by June 30th for the fall semester and November 30th for the spring semester.

Please note: The process of establishing eligibility for accommodations can take up to two weeks. Students MUST attend an information session to obtain their ADA/504 Accommodation Plan.

If you have questions regarding this process, please contact the Center for Student Success at 732-255-0456.

Gina Zippo-Mazur, MS, CRC, CPRP
College Drive P.O. Box 2001
Toms River, NJ 08754-2001
P: 732-255-0456 F: 732-864-3860
gzippo-mazur@ocean.edu
GUIDELINES FOR DOCUMENTATION OF DISABILITY

Provide copies of all appropriate documentation according to the following guidelines. DO NOT SUBMIT ORIGINALS

If you are a student who received services from a Child Study Team in high school, please provide copies of the following:

- Summary of Performance (SOP)
- Psychological Evaluation (within the last 3 years is preferred)
- Educational Evaluation (within the last 3 years is preferred)
- Individual Education Plan (IEP, Junior and Senior year only)
- School Social Worker Report

If you are a student who has a physical, sensory, health-related, chronic illness or medical disability, please have the appropriate medical professional provide a current medical report using FORM A (pink) included in the Intake Packet.

- Deaf/Hearing-Impairment
- Blind/Low Vision
- Traumatic Brain Injury
- ADD/ADHD
- Central Auditory Processing
- Spinal Cord Injury
- Chronic Illness

If you are a student who has a psychiatric or psychological diagnosis, please have the appropriate mental health professional provide information about your current status using FORM B (green) included in the Intake Packet.

To ensure delivery of confidential documents, Please drop off all documents to:

Center for Student Success
Ocean County College – Main Campus
Library Rm. #124
Attention: Gina Zippo-Mazur

* Ocean County College Disability Services reserves the right to request up to date information for approval of accommodations.
STUDENT INTAKE FORM

Instructions
The student completes this form. Please answer each question. The essay is required can be handwritten or typed. The information gathered using this form can assist in determining appropriate services and is viewed only by disability services staff. Return the completed form with documentation of your disability.

General Information
Today’s Date _______ / _______ / __________
Student Name ________________________________________________________________
Date of Birth _____________________________
OCC Student ID # __________________________________ Email Address ________________________________
Street Address ____________________________________________________________________________
City ____________________________________ State ________________ Zip ____________________________
Preferred Phone # ________________________________ Alt. Phone # _____________________________ (circle one: WORK  HOME  CELL)
How did you learn about OCC Disability Services? ________________________________________________
What, if any, accommodations and/or academic adjustments do you think you will need for access to campus buildings and/or for your academic coursework? Please describe: ____________________________________________________________

Enrollment Information (check all that apply)
☐ I currently attend OCC. I am in my _______ Semester.
☐ I am a Distance Learning student.
☐ I plan to start attending OCC on _____________________________
☐ I am transferring from another college. Name of college ____________________________________________
☐ I am a visiting student from another college. Name of college _________________________________
☐ High School attended or High School Proficiency Exam completion ___________________________ Date graduated _____________________________

Agency Connections
Are you a client of the NJ Division of Vocational Rehabilitation (DVR)? ...... ☐ Yes  ☐ No
If you are, who is your Rehabilitation Counselor? ____________________________________________
Are you a client of the Commission for the Blind? ...........................................☐ Yes  ☐ No
If you are, who is your case manager? __________________________________________________________
Are you working with any other agency? ..........................................................☐ Yes  ☐ No
If yes, name of agency ______________________________________________________________________
Name of contact person _______________________________________ Phone number: ____________
Medical Information
Have you ever had a medical or psychiatric diagnosis? □ Yes □ No

If yes, please provide the diagnosis and information about how this impacts you as a student.

If you have completed information above, please have the appropriate professional complete Form A or Form B that are attached to this Student Intake Form.

Have you ever had an illness or condition that has caused you to be absent from school for more than 1 week? □ Yes □ No

If yes, please describe

List any prescription medications that you are taking:

Describe how the prescribed medication(s) might impact you in learning or studying:

Work Experience
What is your career goal?

Are you currently employed? □ Yes □ No

If yes, how many hours per week? __________________

If yes, please briefly describe where you work and your duties:

What jobs have you held in the past?

Checklist of Accessibility Needs (check all that apply)

HEARING □ Hard of Hearing □ Deaf
  ○ Use Sign Language Interpreter  ○ Use CART  ○ Use C-Print

VISION □ Visual Impairment
  ○ Use ZoomText or VoiceOver  ○ Use audio books  ○ Use CCTV or magnifiers

  □ Legally Blind
  ○ Use ZoomText or VoiceOver  ○ Use audio books  ○ Use CCTV or magnifiers

  □ Blind
  ○ Use JAWS  ○ Use MAGIC

MOBILITY □ Require ramps and automatic doors to access campus buildings
  ○ ADA table and/or chair required

CENTRAL AUDITORY PROCESSING □
ADD/ADHD □
STUDENT INTAKE FORM, continued

Academic Challenges (check all that apply)

READING
- □ Poor phonics
- □ Slow reading rate
- □ Understanding what I read
- □ Difficulty finding important points or main ideas
- □ Confusion between similar words
- □ Remembering what I read

WRITING
- □ Frequent spelling errors
- □ Letter reversals
- □ Overly large handwriting
- □ Slow writing rate
- □ Problems with capitalization, punctuation and grammar
- □ Difficulty copying from board
- □ Poorly formed letters or difficulty with spacing
- □ Writing lacking organization and development of ideas

MATH
- □ Problems remembering math facts
- □ Difficulty recalling arithmetic operations
- □ Problems with reasoning and abstract concepts
- □ Confusion or reversal of numbers, number sequences or math symbols
- □ Difficulty reading or understanding word problems
- □ Copying problems from the board
- □ Difficulty keeping columns of numbers in line
- □ Completing homework independently
- □ Taking tests

SPOKEN LANGUAGE
- □ Remembering or understanding oral instructions
- □ Difficulty expressing ideas or thoughts out loud
- □ Problems describing events or stories in proper sequence
- □ Not comfortable speaking in class

STUDY SKILLS
- □ Poor organization skills
- □ Poor time management of skills
- □ Difficulty beginning projects
- □ Difficulty completing projects and papers by due date
- □ Poor note taking skills
- □ Problems finding and using information from different sources
- □ Test anxiety
- □ Poor recall of studied material
- □ Problems with attention and concentration

SOCIAL SKILLS
- □ Difficulty “reading” other people - body language and facial expressions
- □ Problems interpreting or understanding subtle messages such as sarcasm, teasing, banter, or jokes
- □ Confusion relating to time, directions or visual motor coordination
- □ Inability to perform well at sports or games
- □ Poor judgment leading to behavioral problems
- □ Feelings of rejection due to learning problems
- □ Talking out of turn or too loudly

Your signature: ____________________________________________ Date: ________________________

Essay on the last page is required.
STUDENT INTAKE FORM, continued

Students able to write by hand, please use this sheet of paper. Students not able to write by hand may type the essay. Additional pages may be added.

Please write a 3 paragraph essay. First, describe your academic strengths and weaknesses. Next, describe how your disability affects your performance in school. Finally, describe what you hope to achieve at Ocean County College.

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VERIFICATION OF PHYSICAL DISABILITIES & HEALTH DISORDERS

The following information will assist the DS staff in collaborating with the student to determine appropriate accommodations. Documentation serves as a foundation that legitimizes a student’s request for accommodations.

This documentation requires the expertise of a physician or other medical professional with experience and expertise in the area for which accommodations are being requested. This professional must be an impartial individual who is not a family member of the student. The name and contact information for the professional must be clearly stated.

Following Family Education Right and Privacy Act (FERPA), information submitted will become an educational record and can be released to the student named below upon his/her request.

Student Name ________________________________ Date of Birth ________________________________

Please provide a clear statement of the medical diagnosis of the disability or illness:

____________________________________________________________________________________________________________

____________________________________________________________________________________________________________

____________________________________________________________________________________________________________

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____________________________________________________________________________________________________________

**Attach current audiogram for deaf/hearing impairment or visual acuity measurements for blind/low vision. For head/brain injury, attach summary of cognitive and achievement measures utilized and results including standardized test scores used for diagnosis.
Describe the current impact the medical diagnosis has on the student’s educational abilities and the limitations of the disability on learning or other major life activities.

______________________________________________________________________________________________________________
______________________________________________________________________________________________________________
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______________________________________________________________________________________________________________

List current medications and dosages and include the impact of medication on memory and learning.

______________________________________________________________________________________________________________
______________________________________________________________________________________________________________
______________________________________________________________________________________________________________
______________________________________________________________________________________________________________
______________________________________________________________________________________________________________
______________________________________________________________________________________________________________

Please list specific and reasonable academic accommodations for the student’s needs in a campus or educational environment (classroom, lecture or lab).

______________________________________________________________________________________________________________
______________________________________________________________________________________________________________
______________________________________________________________________________________________________________
______________________________________________________________________________________________________________
______________________________________________________________________________________________________________
______________________________________________________________________________________________________________

Medical Professional’s Contact Information. Please attach cognitive and achievement diagnostic reports including standardized testing scores.

PROFESSIONAL’S NAME, TITLE, AND CREDENTIALS

PROFESSIONAL’S SIGNATURE
DATE

PROFESSIONAL’S ADDRESS
STATE
ZIP CODE

PROFESSIONAL’S TELEPHONE
PROFESSIONAL’S EMAIL

NOTE: Further assessment by an appropriate professional may be required if co-existing learning disabilities or other disabling conditions are indicated.
VERIFICATION OF PSYCHIATRIC/PSYCHOLOGICAL DISORDERS

The information provided below will assist the DS staff members in collaborating with the student to determine appropriate academic accommodations. Documentation serves as a foundation that legitimizes a student’s request for accommodations.

A diagnosis by a licensed mental health professional (includes licensed clinical social workers, licensed professional counselors, psychologists, psychiatrists and neurologists) is required. This professional must be an impartial individual who is not a family member of the student. The name and contact information for the professional must be clearly stated. All questions must be answered to provide accommodations to the student.

Student Name __________________________________________________________ Date of Birth __________________________

A. Please respond to the following items regarding the student named above. (Please type or print)

1. What is the student’s DSM diagnosis?

   a. State the student’s current symptoms that meet the criteria for this diagnosis.

   b. State the age of onset of symptoms described by DSM.

   c. What is the severity of the condition?

   d. State the frequency of your appointments with this student and the date of your last contact.

3. List and describe measures and instruments used to support the Psychiatric/Psychological diagnosis. Reports may include formal instruments, medical examinations, structured interview protocols, performance observation and unstructured interviews. If results from informal or non-standardized methods of evaluation are reported, a clear explanation of their role and significance in the diagnostic process should be included.

* ADA and sec. 504 define a disability as a physical or mental impairment that substantially limits one or more major life activities such as learning.
4. Describe the symptoms related to the student’s condition that causes significant impairment in a major life activity.

____________________________________________________________________________________________________________
____________________________________________________________________________________________________________

5. List the student’s current medication(s), dosages, frequency, and adverse side effects.

____________________________________________________________________________________________________________
____________________________________________________________________________________________________________

6. Does the student have a disability* as a result of his/her condition that warrants accommodations?  □ Yes  □ No

(Check “yes” if the student’s condition requires accommodations.)

7. If yes, please state specific recommendations regarding accommodations for this student and a rationale as to why these accommodations are warranted based upon the student’s functional limitations. Indicate why the accommodations you recommend are necessary.

____________________________________________________________________________________________________________
____________________________________________________________________________________________________________
____________________________________________________________________________________________________________
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B. Provider Contact Information.  Please attach cognitive and achievement diagnostic reports including standardized testing scores.

<table>
<thead>
<tr>
<th>PROVIDER NAME AND TITLE</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>PROVIDER SIGNATURE</td>
<td>DATE</td>
</tr>
<tr>
<td>PROVIDER LICENSE NUMBER</td>
<td>ISSUING STATE</td>
</tr>
<tr>
<td>PROVIDER ADDRESS</td>
<td>STATE</td>
</tr>
<tr>
<td>PROVIDER TELEPHONE</td>
<td>PROVIDER FAX NUMBER</td>
</tr>
</tbody>
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* ADA and sec. 504 define a disability as a physical or mental impairment that substantially limits one or more major life activities such as learning.