

Santiago Canyon College

DISABLED STUDENT PROGRAMS & SERVICES (DSPS)

APPLICATION FOR SERVICES

DSPS Program Overview:

DSPS provides educational services and access for eligible students with documented disabilities who intend to pursue coursework at Santiago Canyon College. A variety of programs and services are available which afford eligible students with disabilities the opportunity to participate fully in all aspects of college programs and activities through appropriate and reasonable accommodations. Completion of this form constitutes an agreement to apply for Disabled Student Programs & Services (DSPS).

Date of Application: _____ SSN/ID: _____
 Name: _____ Telephone: _____
 Address: _____ Cell phone: _____
 City, Zip: _____ Work phone: _____
 Email: _____ Birth Date: _____ Age: _____

The following questions are designed to help us evaluate your needs for reasonable accommodations. Verification of disability must be on file in order to receive DSPS services. Providing personal information is strictly voluntary.

1. How did you hear about our program? Instructor/Counselor: _____ Self-referred
 Course syllabus College publication Other _____

2. What is your disability? _____

3. What educational difficulties do you experience because of your disability? _____

4. What services/accommodations are you requesting? _____

5. What educational accommodations have you received in the past? _____

Indicate setting: K-12 Community College University

6. Are you taking any medication(s) that may affect your learning? Yes No

Name of medication(s): _____

For what condition(s): _____ Side effects: _____

7. What is your educational goal? Certificate Associate Degree University Transfer
 High School Diploma/GED Basic Skills Personal Development Undecided

What is your major/area of interest? _____

8. Have you attended any other college or university? Yes No

If yes, Institution: _____ Degree/# of Units: _____

CONTINUE ON REVERSE SIDE

9. Are you required to enroll in a certain number of units? Yes No

If yes, how many? _____

10. Are you currently employed? Yes No Hours per week: _____

11. Are you a client of the Department of Rehabilitation? Yes No

If yes, Counselor: _____ Phone: _____

What is your disability according to the Dept. of Rehab? _____

I understand that I must fulfill requirements for participation in the DSPTS Program. If I am eligible for services, I will receive printed information on DSPTS service provision policies and I understand there are consequences of failing to comply with the rules for responsible use of DSPTS services. I understand that I will be notified in writing before any action is taken to suspend services. By signing this application I affirm that I understand and agree to follow DSPTS Program responsibilities of students.

Student Signature: _____ **Date:** _____

Parent Signature (if under 18): _____ **Date:** _____

The Community College District uses the information requested on this form for the purpose of determining a student's eligibility to receive authorized special services provided by the Disabled Students Programs and Services (DSPTS) Program. Personal information recorded on this form will be kept confidential in order to protect against unauthorized disclosure. Portions of this information may be shared with the Chancellor's Office of the California Community Colleges or other state or federal agencies; however, disclosure to these parties is made in strict accordance with applicable statutes regarding confidentiality, including the Family Educational Rights and Privacy Act (20 U.S.C. 1232(g)). Pursuant to Section 7 of the Federal Privacy Act (Public Law 93-579; 5 U.S.C. § 552a, note), providing your social security number is voluntary. The information on this form is being collected pursuant to California Education Code Sections 67310-67312, and 84850; and California Code of Regulations, Title 5, Section 56000 et seq.

FOR OFFICE USE

I hereby certify this student is eligible for DSPTS services based on:

- Observation by DSPTS professional staff with review by the DSPTS Coordinator
- Assessment by appropriate DSPTS professional Staff
- Review of documentation provided by appropriate agencies or certified licensed Professional outside of DSPTS.

Primary Disability: _____ Secondary Disability: _____

DSPTS Professional Signature: _____ Date: _____

DSPTS Coordinator Signature: _____ Date: _____

SLO Assessment:

Student is able to:	Yes	Somewhat	No
1. Identify disability(ies)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. State educational limitations	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Articulate needed accommodations	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Notes: _____