

Intake form: Access & Accommodation Services

If you have a physical, psychological, medical, or learning disability that may impact your ability to complete this form, please contact the Access & Accommodation Office (Room C-219; 585.343.0055 extension 6351) for assistance.

Please read this form in its entirety. Complete all sections to the best of your ability.

Access Services at Genesee Community College provides services and accommodations to students with disabilities in order to provide equal access to educational programs and activities.

- It is important to have current and comprehensive documentation from a **qualified health provider** (QHP), who is unrelated to the person applying for the accommodation(s).
- The QHP providing the documentation should be *actively (or recently) working* with the applicant and has assessed the condition for which the accommodations are being requested.
- This information is required to assist with the determination and provision of appropriate and reasonable accommodations, auxiliary aids and services.

Please attach any assessments (medical, psychological, psychiatric, educational and/or other information) to support the information provided in the intake form. Additional documentation may be required. Feel free to share this application with your QHP to provide the appropriate information. Incomplete forms will be returned to the student to complete.

Today's Date: _____

Student Information

Last Name: _____ First Name: _____

Other names we may know you by: _____ GCC 800# _____

Preferred Name: _____

Date of Birth: _____ Preferred Phone: _____

Home Address: _____

City, State, Zip: _____

Email address: _____

Signature: _____

_____ By checking this line, I acknowledge that if it is determined that I am eligible for accommodations, the accommodation notices will be delivered to my instructors electronically. Electronic communication with my instructors does not ensure the use of accommodations. I understand that it is my responsibility to speak with my instructors so that my accommodations are applied to my academic experiences.



Academic Information

Student Status:

Are you currently enrolled or an incoming student? _____

For which Semester? _____

Have you ever been a student at GCC before: (check) Yes _____ No _____

Your Degree Program: _____

Are you a transfer Student or an ACE Student? _____

If you received transfer credit from another post-secondary institution, did you utilize disability or access services there? (Check) Yes _____ No _____

If yes, please complete the following:

Name of Institution: _____

Services Received: _____

Check if you receive any or all of the following:

ACCES-VR Support _____ SSI/SSD _____ Other _____

If yes, please provide the contact information for your contact:

Name: _____ Phone: _____

Accommodations Information

Please list your diagnosis(es) or condition(s) related to this request:

Which type of accommodations are you requesting (check all that apply):

Academic _____ Residence _____

Please use the following space to discuss the major life activities currently and substantially impaired or limited by the student's diagnosis/condition. Please tell us how this affects the student's academic performance:



For which accommodations is the student applying (please list):

All documentation is kept strictly confidential and is not released without written permission from the student or by order of a court. Please submit documentation and/or inquiries to (mail, drop off or email only):

Access & Accommodation Services
 Genesee Community College
 One College Rd
 C219
 Batavia NY 14020
 585.343.0055 x6351 (p)
 585.345.6806 (f)
access@genesee.edu

*Please note that we often utilize electronic methods to share needed information. The confidentiality of electronically shared information cannot be guaranteed. If you have any concerns regarding your confidentiality, please only drop off your documents.

Information from Qualified Health Provider (QHP)

Release of Information (if you are allowing a QHP to complete the information below)

I, _____ (student name), authorize the above-named qualified health professional to release information to Genesee Community College Access Services for the purpose of determining appropriate accommodations for my permanent or temporary disability while a student at Genesee Community College.

Signature of Student: _____ Date: _____

Signature of Parent/Guardian: _____ Date: _____

Qualified Health Provider Information

(if more than one, please add additional sheets)
 In order to obtain accommodations, an individual with a disability under the Americans with Disabilities Act (ADA) and/or Section 504, the person must have a physical or mental impairment that substantially limits one or more major life activities. Major life activities include,



but are not limited to walking, seeing, hearing, speaking, breathing, learning, working caring for one's self and or other similar/related activities.

Please note the following regarding documentation:

- **Documentation must be printed on professional letterhead.** If letterhead is not utilized, the official stamp from the practitioner must be included.
- A diagnostic statement from a qualified professional (counselor, social worker, psychologist, neuropsychologist, educational psychologist, learning disability specialist, psychiatrist, or medically-based physician) should identify the disability, the date of the evaluation, and a date of the original diagnosis of the disability.
- **Prescriptions from a physician are NOT acceptable forms of documentation.**
- The credentials and signature of the evaluator, medical professional, etc., must be stated.
- Documentation must include the minimum of a diagnosis and summary of current impact on the individual. Please include any tests administered, with scores, and recommendations of areas where accommodations might be needed. Please add additional sheets if needed.

Name & Credentials: _____

Practice Address: _____

City, State, Zip: _____

License Number & State of Licenser: _____

Signature: _____

Please place practice stamp here:

Diagnostic Information

Date of Initial Diagnosis: _____

Date of Most Recent Evaluation: _____

Diagnosis (Please list all and include ICD 10 Code for medical or psychological): _____

Medications (name & dosage): _____
