Holmes Community College  
Disability Support Services  
Intake Form

DATE ______________ SEMESTER/YEAR  Fall __ Spring __ Summer__  Yr. ______

PERSONAL INFORMATION:

Student’s Name ____________________________________________________________

Holmes ID# ___________________ Holmes Email ________________________________

Address ______________________ City ______________ State ______ Zip Code ______

Home Phone ___________________ Cell Phone ___________________ Other ____________

Date of Birth _____________ Emergency Contact Name/# ______________________

DISABILITY INFORMATION: This section must be complete before the student will be considered for services. (Categories: Check all that apply)

_____ Specific Learning Disability  _____ Mobility
_____ Visual  _____ Psychological
_____ Neurological  _____ ADD/ ADHD
_____ Seizures  _____ Auditory
_____ Chronic Illness  _____ Physical
_____ Other: _______________________________________________________________

➢ Specific Diagnosis(es): ____________________________________________________

➢ Specific Accommodations Requested: _______________________________________

➢ Type of Document Submitted: _____________________________________________

➢ Date Submitted: __________________

ACADEMIC INFORMATION:

Major __________________________ Freshman or Sophomore

VOCATIONAL REHABILITATION INFORMATION:

Do you receive services from Vocational Rehabilitation or some other area of rehabilitation services? ______ If yes, please provide name, address, and phone number of your VR Counselor:

Name: __________________________________ Phone Number: _________________________

Address: ________________________________________________________________

Revised May 2011
VERIFICATION INFORMATION:
I give permission to Disability Support Services to contact my parents and/or legal guardians and my diagnosing healthcare professional in their attempt to verify my eligibility for academic accommodations. I understand that this permission extends to the verification process only.

_______________________________________________________         ________
Student Signature                                                                                        Date

RELEASE OF RECORDS INFORMATION:
I hereby authorize Holmes Community College’s Disability Support Services to communicate with the following: *(Your check in the blank gives us permission to talk with these people. If there are persons under each category you wish to exclude from communication, please write their names on the blank.)*

_____ Parents
 List exclusions: __________________________________________

_____ HCC Faculty/Staff, On Campus Services (i.e. Health Clinic, Residence Life, etc.)
 List exclusions: __________________________________________

_____ Off Campus Services (i.e. Professionals, Schools, Vocational Rehab., etc.)
 List exclusions: __________________________________________

Communication as denoted above may include obtaining and/or releasing student’s historical and/or current information regarding assessment, diagnosis, needs, recommendations, treatment, prior services, academic records, performance, or information that may relate to accommodating student’s needs on HCC’s campus. This consent form will be valid until revoked by student. A photocopy of the original consent form shall be as valid as the original consent form.

Signature_________________________ Date: __________________________

DISCLOSURE INFORMATION:
By completing and signing this intake application, you are voluntarily disclosing a disorder and requesting accommodations. You understand that disclosure of your disorder at this time does not necessarily confirm your eligibility status for services or accommodations. You also understand that the length of the verification process will depend upon the appropriateness of the document you have submitted. In addition, you understand that all information submitted to this office is to be completely confidential and used only for this institution’s commitment and obligation to students with disabilities.

By signing below, you confirm that you have read and understand this document.

_______________________________________________________        ___________________
Student Signature                                                                                   Date

_______________________________________________________        ___________________
DSS Staff Signature                                                                             Date