SAN DIEGO COMMUNITY COLLEGE DISTRICT (SDCCD)
Disability Support Programs and Services (DSPS)

Application for Services

TODAY'S DATE: _____ CSID: _____

Last Name:_____ First Name: _____ MI:_____

Address:_____ City, State and Zip:_____

DOB:_____ Home Phone:_____ Cell Phone: _____

E-mail Address:_____

*Emergency Contact Person*_____

*Relationship to Student: :*_____ *Phone:*_____

GENERAL INFORMATION

Have you applied to City, Mesa, Miramar College(s) (Admissions)? Yes _____ No _____

Have you taken the College/CE Assessment/Placement Tests? (if yes, include scores if available)

MATH: No____Yes_____ ENGLISH: No____Yes_____ ESL: No____Yes_____

DEAF ENGLISH: No____Yes_____ TABE: No____Yes_____

What is your current educational goal (if known)? _____

Would you like assistance with Voter Registration? Yes____ No____

Have you ever received services from any SDCCD DSPS Office? No____ Yes____ Year_____ Where? _____

Are you receiving services through? (check all that apply)

____EOPS ____Cal WORKS ____WorkAbility III ____Financial Aid ____SSI/SSDI ____Veterans

____Department of Rehabilitation ____Regional Center ____TRACE ____Other (list here) _____

Counselor(s):_____

EDUCATIONAL HISTORY

Are you having academic difficulties? (describe)_____

What is the highest level of education completed? (Check all that apply)

8☐ 9☐ 10☐ 11☐ 12☐ HS diploma☐ GED☐ Cert. of Completion☐

Highest college degree completed_____Graduation Date: _____

High School or other Colleges attended: _____

Have you ever received Special Ed./504/IEP/Resource/Remedial support? Yes ____ No ____

If you are currently working, please describe employment:

Where? _____

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DISABILITY INFORMATION
Please respond to all by checking yes or no

	Yes	No		Yes	No
Acquired Brain Injury			**Psychological Disability**		
Brain Tumor			History of mental health problems		
Stroke			History of Substance Abuse		
Traumatic head injury			Inpatient/Outpatient Counseling		
Hearing Loss			**Other Disabilities**		
Deaf			Aids/ HIV		
Hard-of-hearing			Attention Deficit Disorder (ADD or ADHD)		
Use Sign Language			Autism/ Asperger Syndrome		
Cochlear implant/ Hearing aid			Cystic Fibrosis		
Mobility			Diabetes		
			Epilepsy/ Seizures		
Amputation			Gastrointestinal Disorder		
Arthritis			Hemophilia		
Cerebral Palsy			Immune System Disorder		
Multiple Sclerosis			Other Health: _____		
Orthopedic					
Post Polio			**Learning Disability (LD)**		
Respiratory					
Spinal Cord Injury			Requesting first time LD testing		
Other: _____			LD has been verified by a:		
			High School		
Speech / Language Disability			University		
			CA Community College		
Aphasia			Other: _____		
Dysarthria					
Dysfluency			**DDL/Intellectual Disability**		
Other:					
Visual Disability					

It is the responsibility of the student seeking accommodations and services to provide a comprehensive evaluation verifying the disabling condition(s) and the resulting educational limitations.

Student Signature:_____ Date:_____

Office Use Only **Received By:**_____ **Date:**_____