UNIVERSITY OF ILLINOIS SPRINGFIELD
DISABILITY SERVICES
APPLICATION FOR SERVICES

UIN _____ Date _____

Last Name _____ First Name _____ MI ____

Male_____ Female_____ Other Identity_____
(*Please Specify)*

Date of Birth_____

Permanent Address_____

City_____State_____Zip_____

Permanent Phone (_____) _____Country of Citizenship_____

Campus Address_____

City_____ State_____ Zip_____

Campus/Cell Phone (___) _____ Email Address_____

Name of Parent or Guardian _____

Undergraduate _____ Graduate _____

Are you a veteran of US military service? _____Yes _____No

RACE/ETHNICITY (optional for statistical purposes)

Are you Hispanic or Latino? ____Yes ___No

Select one or more races:

_____American Indian/Alaska Native _____Asian _____Black/African American

_____Native Hawaiian or Other Pacific Islander _____White

ACADEMIC HISTORY

High Schools Attended	**Dates of Attendance From To**	**Disability-Related Accommodations / Services**

Did you have an IEP? ____ Yes ____ No **Did you have a 504 plan? ____ Yes ____ No**

Colleges / Universities Attended	**Dates of Attendance From To**	**Disability-Related Accommodations / Services**

Dear Prospective Student: Thank you for your interest in services for students with disabilities offered by the Office of Disability Services (ODS). It is important that you complete and return this application **with** supporting disability documentation as soon as you are admitted to the university or are aware of a disability-related need for services. Such information will help us work with you to plan effective academic adjustments, auxiliary aids, or services during your tenure as a student at Illinois Springfield. Refer to the ODS document entitled *Documentation Requirements* for specific documentation requirements for your disability. **Please note that services cannot begin until a completed application (application and disability documentation) is on file in the ODS Disability Services Office.**

GENERAL NATURE OF DISABILITY / DISABILITIES

Please describe your disability, include diagnosis as well as the cause and date of onset.

_____

_____

_____

Do you receive SSI or SSDI? _____Yes ____No

Do you receive support through your state rehabilitation services office? _____Yes _____No

If yes, please provide counselor information below

Name: _____ City: _____

State: _____ Zip: _____

DISABILITY-SPECIFIC INFORMATION

_____

_____

Please list current medications:_____

Are there any side effects with these medications? If yes, please explain. _____Yes _____No

_____

USE OF ASSISTIVE TECHNOLOGY, DOCUMENT CONVERSION, OR CAPTIONING

Check all that apply:

Screen Reader _____ Speech Recognition _____ Keyboard Adaptations _____

MP3's _____ e-text_____ Large Print _____ Captioning_____

Please list programs and describe use:

_____

_____

_____

TO BE COMPLETED ONLY BY INDIVIDUALS WITH PRIMARY OR SECONDARY VISION DISABILITIES

Travel Aides: Cane _____ Dog Guide _____ Other _____

Previous Mobility Training: _____

When _____ How long _____

Do you travel independently? Yes_____ No_____

TO BE COMPLETED ONLY BY INDIVIDUALS WITH PRIMARY OR SECONDARY HEARING DISABILITIES

Do you wear hearing aids? No _____ Yes _____ If Yes, One ear_____ Bilateral_____

Primary means of expressive and receptive communication:

Speech Reading _____ FM System _____ Sign Language _____

If so, what type? ASL _____ Other _____

TO BE COMPLETED ONLY BY INDIVIDUALS WITH DISABILITIES AFFECTING MOBILITY

Do you use any mobility aids? Prosthesis (specify) _____

Braces ___ Crutches ____ Cane ____ Manual Wheelchair ____ Motorized wheelchair/cart ____

Other (specify) _____ Do you require personal assistant (PA) help? Yes____ No____

UNIVERSITY OF ILLINOIS SPRINGFIELD ENROLLMENT

College_____ Major_____

Current Year in School: Freshman____ Sophomore____ Junior____ Senior____ Graduate____

Entrance date: Summer Session _____ Fall ____ Spring ___ Year_____

Are you an Online Degree seeking student? _____Yes _____No

Are you enrolled in any online courses this semester? _____Yes _____No

STUDENT AUTHORIZATION FOR RELEASE OF INFORMATION

I, the undersigned, understand that in order for the Office of Disability Services (ODS) to verify my disability, as well as the functional manifestations of my disability for which academic adjustments, auxiliary aids and/or other accommodative services may be required, ODS must obtain pertinent student evaluations, psychological reports, transcripts, and medical reports. I understand that to obtain these reports, this form must be signed and on file in the Office of Disability Services (ODS).

I understand that no one other than ODS personnel has immediate access to my ODS files, and that any information regarding my disability which is gained from these files shall be considered **confidential** and will only be shared with others within the institution on a need-to-know basis. I further understand that my reports will not be released by ODS except in accordance with federal and state laws.

Therefore, for the purposes noted above and in accordance with the conditions specified, I hereby authorize release of information from reports to authorized personnel at the University of Illinois Springfield and the Office of Disability Services. I understand that I may revoke this consent at any time.

SIGNED _____ ***DATE*** _____

PARENT/GUARDIAN(IF STUDENT IS UNDER 18 YRS. OF AGE) _____ **DATE** _____

MEDICAL PROFESSIONAL/AGENCY AUTHORIZATION FOR RELEASE OF INFORMATION

I, authorize_____to release
(Person or Agency)

_____
(State specific nature of information to be disclosed)

Concerning_____
(Receiving Agency or Individual)

_____
(Receiver's Address)

for the purpose of_____
(Further evaluation, continuing treatment, etc.)

This consent is valid until _____

I understand that I may revoke this at any time and that the above-mentioned individual or agency authorized to receive this information has the right to inspect and copy the information to be disclosed. It has been explained to me that if I refuse to consent to this release of information, the following are consequences (specify, if any):

_____

WITNESS:_____ ***SIGNATURE:***_____

DATE:_____ ***UIN:***_____ ***DATE:***_____

* If signature is not of recipient, indicate legal relationship of signatory to recipient and legal basis on which consent is given for recipient.