

MARIA COLLEGE DISABILITY SERVICES

DISABILITY DOCUMENTATION GUIDELINES

All students who register with Accessibility Services Office at Maria College are required to meet individually with the Director of Counseling and Accessibility Services, Kim Noakes to create an accommodation plan based on the type of disability the student has and to review the student's documentation. Students have a responsibility to provide appropriate and timely disability-related documentation to ACCESSIBILITY SERVICES in order for accommodation plans to be developed.

Students with learning and/or ADD should refer to the guidelines in Documentation of a Learning Disability /ADD. Students with all other disability diagnoses (mobility, visual and hearing; chronic medical conditions; psychiatric; cognitive, and substance abuse/recovery) must provide documentation which responds to the 7 template items listed below. These guidelines have been adapted from those developed by the Association on Higher Education and Disability (www.ahead.org).

DISABILITY DOCUMENTATION GUIDELINES

Notice to Clinicians:

Please provide a brief narrative to address the template items in our Provider Documentation form which the student is providing. (a doctor's script would not be appropriate for documentation related to a disability) A completed form may be Faxed to 518-730-9628 or scanned and emailed to Kim Noakes, Director of Counseling and Accessibility Services at Knoakes@mariacollege.edu. Documentation can be type-written on your letterhead but must include the all seven categories listed below.

Please remember that the student will not be formally registered with ACCESSIBILITY SERVICES, nor will they be able to receive any disability-related services and accommodations, until the student has met with an ACCESSIBILITY SERVICES staff member for an intake meeting appointment to discuss individual need and documentation is reviewed. An individualized accommodation plan is developed with the student at that meeting. Please call the Director of Counseling and Accessibility Service Coordinator (518) 861-2508 if you have any questions. Thank you in advance for your assistance.

Seven Categories of Documentation:

1. The credentials of the evaluator/s

The best quality documentation is provided by a licensed or otherwise properly credentialed professional who has undergone appropriate and comprehensive training, has relevant experience, and has no personal relationship with the individual being evaluated. An appropriate

match between the credentials of the individual making the diagnosis and the condition being reported is expected (e.g., an orthopedic limitation might be documented by a physician, but not a licensed psychologist).

2. A statement identifying the disability

Acceptable documentation includes a clear diagnostic statement that describes what the condition is and how it was diagnosed. While diagnostic codes from the Diagnostic Statistical Manual of the American Psychiatric Association (DSM) or the International Classification of Functioning, Disability and Health (ICF) of the World Health Organization are helpful in providing this information, a clinical description will also convey the necessary information.

3. A description of the diagnostic methodology used

Quality documentation includes a description of the diagnostic criteria, evaluation methods, procedures, tests and dates of administration, as well as a clinical narrative, observation, and specific results. Where appropriate to the nature of the disability, having both summary data and specific test scores (with the norming population identified) within the report is recommended. Diagnostic methods that are congruent with the particular disability and current professional practices in the field are recommended. Methods may include formal instruments, medical examinations, structured interview protocols, performance observations and unstructured interviews. If results from informal, non-standardized or less common methods of evaluation are reported, an explanation of their role and significance in the diagnostic process will strengthen their value in providing useful information.

4. A description of the current functional limitations

Information on how the condition(s) currently impacts the individual provides useful information for both establishing a disability and identifying possible accommodations. A combination of the results of formal evaluation procedures, clinical narrative, and the individual's self-report is the most comprehensive approach to fully documenting impact. The best quality documentation is thorough enough to demonstrate whether and how a major life activity is substantially limited by providing a clear sense of the severity, frequency and pervasiveness of the condition(s). While relatively recent documentation is recommended in most circumstances, common sense and discretion in accepting older documentation of conditions that are permanent or non-varying is recommended. Likewise, changing conditions and/or changes in how the condition impacts the individual brought on by growth and development may warrant more frequent updates in order to provide an accurate picture. It is important to remember that documentation is not time-bound; the need for recent documentation depends on the facts and circumstances of the individual's condition. In most cases, documentation should be current within the past 3-5 years; however some documentation that is older may also be relevant. In some cases, previous or more recent documentation may be requested to draw connections between the student's condition and the accommodation being requested.

5. A description of the expected progression or stability of the disability

It is helpful when documentation provides information on expected changes in the functional impact of the disability over time and context. Information on the cyclical or episodic nature of the disability and known or suspected environmental triggers to episodes provides opportunities to anticipate and plan for varying functional impacts. If the condition is not stable, information on interventions for exacerbations (including the individual's own strategies) and recommended timelines for re-evaluation are most helpful.

6. A description of current and past accommodations, services and/or medications

The most comprehensive documentation will include a description of both current and past medications, auxiliary aids, assistive devices, support services, and accommodations, including their effectiveness in ameliorating functional impacts of the disability. A discussion of any significant side effects from current medications or services that may impact physical, perceptual, behavioral or cognitive performance is helpful when included in the report. While accommodations provided in another setting are not binding on the current institution, they may provide insight in making current decisions.

7. Recommendations for accommodations, adaptive devices, assistive services, compensatory strategies, and/or collateral support services

Recommendations from professionals with a history of working with the student provide valuable information for review and the planning process. It is most helpful when recommended accommodations and strategies are logically related to functional limitations; if connections are not obvious, a clear explanation of their relationship can be useful in decision making. While the College has no obligation to provide or adopt recommendations that would fundamentally modify the course or degree requirements. Those accommodation recommendations that are congruent with the programs, services, and benefits offered by the College may be appropriate.

Example of Documentation

A student who is providing a medical providers documentation can access a copy of the colleges "Provider Documentation Form" on our web site. This is the appropriate form needed to meet the medical diagnosis criteria for reporting a medical disability (ie. Depression, Anxiety etc.) Please have your provider answer all questions on the form related to your individual situation.