Chaffey College
Disability Programs & Services

Note * The Disability Programs and Services office is revamping the DPS specific SET process.

The Disability Programs and Services office can in certain cases offer a DPS specific Senior Early Transition process for students with disabilities at select high schools within Chaffey Colleges district.

**Dates will be confirmed for selected schools on a first come, first serve basis once all the documentation has been submitted (IEP's Psychological reports, 504s etc.) Dates will not be confirmed until the appropriate documentation is received.*

First Visit *will consist of the Application and DPS Orientation*

Second Visit *will consist of Placement and Educational Plan Availability (Must have done 1st Appointment)*

Chaffey College
Disability Program and Services

Application/ Contract for Services

To allow Disability Program and Services (DPS) to better assist students with emergency situations, please provide the names of individuals to contact in case of an emergency, your relationship to them, and their telephone numbers. *It is your responsibility to update any changes with DPS and Chaffey College.*

PLEASE PRINT

ID#:_____ Student Name: _____ DOB: _____

Address: _____ City: _____ Zip Code:_____

Contact Number: _____ Panther Email: _____@panther.chaffey.edu
(First Letter of your first name, full last name, last four of your id#) Example: jdoe1234

EMERGENCY CONTACTS

Name: _____ Relationship: _____

Phone Number: _____

Name: _____ Relationship: _____

Phone Number: _____

MEDICATIONS: (*If needed, attach list on separate sheet of paper*)

Name:_____ Purpose:_____

Name:_____ Purpose:_____

Name:_____ Purpose:_____

ALLERGIES: _____

I understand that participation in the Disability Program and Services program is strictly voluntary.

Student Signature: _____ **Date**:_____

Signature of parent or guardian: (*If under 18*) _____

Chaffey College provides educational services and access for eligible students with documented disabilities who intend to Pursue coursework at the college. A variety of Programs and services are available, which afford eligible students the opportunity to participate fully in all aspects of college programs and activities through appropriate and reasonable accommodations. Completion of this form constitutes an agreement to apply for the Disability Programs and Services.

Office Use Only: **Processed on**: ___/___/___ **Initials**: _____

Student Checklist: ☐ Orientation ☐ Assessment ☐ Ed Plan

Primary Diagnosis: Permanent or Temporary with end date of _____
Secondary Diagnosis: Permanent or Temporary with end date of _____

Chaffey College
AUTHORIZATION TO OBTAIN OR RELEASE INFORMATION

Student Name: _____ Birthdate: _____

I authorize: (name of school and contact)

To release the following records: IEP, Psychoeducational Assessment/Report, 504 Plan, Medical/Psychological Documentation, Speech & Language Report

To: Chaffey College/Disability Program Services
5885 Haven Ave
Rancho Cucamonga, CA 91737-3002
909-652-6379/6380

I authorize any licensed physician, medical practitioner, hospital, clinic, or medically-related facility or other agency, school, organization, institution or person that has any records or knowledge of the above-named person to release to Chaffey College, copies of any educational, medical, psychological, or therapy-related information for inclusion in their Chaffey College DPS records.

I understand that the information obtained by Chaffey College will be used by Chaffey College personnel to facilitate planning for appropriate educational placement and services.

I understand that information obtained OR released will be kept confidential and will be limited to professional use only.

I agree a photocopy of this form shall be as valid as the original.

I understand I may request a copy of this form.

I agree this authorization shall be valid for one year from the date shown below, unless I revoke this authorization in writing at any time before the expiration date, and understand that if the student does not attend Chaffey College within one year of the expiration date, the records will be destroyed to ensure security.

_____ _____
Signature of Parent/Guardian (if student is under 18) Date

_____ _____
Signature of Student Date

Chaffey College Disability Programs & Services Disability Verification Form

Student's Name (Print): Last First MI

Student Signature Date

Date of Birth XXX-XX- Social Security # Student ID #

Phone # E-mail

Chaffey College agrees to use the information requested on this form for the purpose of determining a student's eligibility to receive authorized special services provided by the Disability Programs & Services. Personal information recorded on this form will be kept confidential in order to protect against unauthorized disclosure. I hereby consent for Chaffey College DPS to contact certifying professional for additional information if needed.

THIS PORTION IS TO BE FILLED OUT BY THE PHYSICIAN (PLEASE PRINT)

Primary Diagnosis: **AND ICD10/DSMV:**

☐ **Permanent /Chronic** ☐ **Temporary** **Date of Onset:** **End Date or Re-Evaluation Date:**

Severity: ☐ Mild ☐ Moderate ☐ Severe ☐ Other:

Medications (Dosage / Frequency / Side Effects):

Secondary Diagnosis (If Applicable): **AND ICD10/DSMV:**

☐ **Permanent /Chronic** ☐ **Temporary** **Date of Onset:** **End Date or Re-Evaluation Date:**

Severity: ☐ Mild ☐ Moderate ☐ Severe ☐ Other:

Medications (Dosage / Frequency / Side Effects):

Functional Limitations (Certifying Professional must INITIAL next to each limitations resulting from the disabilities above):

_____ Gross motor skills
_____ Fine motor skills
_____ Attention
_____ Concentration
_____ Student may have to leave room intermittently
_____ Requires highly structured learning environment
_____ Long term memory
_____ Short term memory
_____ Walking
_____ Hearing (Attach Verification)
_____ Vision (Attach Verification)

_____ Difficulty sitting for extended times
_____ Difficulty standing for extended times
_____ Difficulty using dominant hand
_____ Processing visual information
_____ Processing auditory information
_____ Receptive language
_____ Expressive language
_____ Other: _____ Please Specify
_____ Handicap Parking (Must Have DMV Placard)
_____ Learning Disability (Attach Verification)

Please submit form to:

Chaffey College Disability Programs & Services
5885 Haven Avenue
Rancho Cucamonga, CA 91737
Phone: (909) 652-6379
Fax: (909) 652-6385

Signature & Title of Certifying Professional:
Name of Treating Professional (Printed):
Agency Name:
Street Address:
City, State & Zip:
Phone # /Fax #: