MONTGOMERY
COUNTY COMMUNITY COLLEGE

OFFICE OF DISABILITY SERVICES
disabilities@mc3.edu

Autism Spectrum Disorder (ASD) Documentation Guidelines

The request for reasonable accommodations must be initiated by the student once the student is confirmed at the College. The student must schedule and participate in an Intake appointment with the Office of Disability Services so that support services and reasonable accommodations can be discussed in an interactive process. Documentation will be reviewed by the Office of Disability Services prior to the appointment. **The Office of Disability Services is responsible for and will make the final determination of reasonable accommodations.**

- Documentation must be completed by a professional qualified by comprehensive training and direct experience in the differential diagnosis of ASD such as a psychologist, neuropsychologist, psychiatrist or other relevantly trained medical doctor.
- The professional completing the form is not a family member of the student or someone who has a personal or business relationship with the student.
- Documentation should include the names, titles, professional credentials, license number, addresses, and phone numbers of the evaluators as well as the date of the report.

Please provide a clear statement of the disability, including the DSM-V diagnosis and a summary of present symptoms:

1. Documentation for eligibility should address the current substantial functional impact(s) of the condition in the educational setting; (the age of effective documentation is dependent upon the disabling condition, the current status of the student and the student's request for accommodations).
2. A summary of assessment procedures and evaluation instruments used to make the diagnosis and a summary of evaluation results, including standardized or percentile scores.
3. Medical information relating to the student's needs should include the impact of medication on the student's ability to meet the demands of the postsecondary environment.
4. Suggestions for reasonable accommodations which are appropriate at the *postsecondary level* are welcome. **Each recommendation should be supported by the diagnosis and clearly linked to the current impact of a functional limitation of the student's disability**.

Disability documentation is confidential and should be submitted only to the Office of Disability Services.

The Office of Disability Services maintains disability files and diagnostic testing information for seven years after the student either graduates, transfers, or leaves the College. After that time, the confidential files are destroyed. If a student does not attend the College but has submitted documentation, the files will be destroyed after two years. Consequently, the student should maintain their own copy of the diagnostic information.

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Autism Spectrum Disorder (ASD) Verification Form

TO BE COMPLETED BY PSYCHIATRIST / PSYCHOLOGIST / OR OTHER QUALIFIED DIAGNOSTICIAN*

(*as specified in College Guideline, see previous page)

The American with Disabilities Act (ADA; 1990; as amended, 2008) and Section 504 of the Rehabilitation Act of 1973 ensure the accessibility and availability of higher education for all qualified persons. Disability Services has the responsibility of implementing provisions of the ADA for persons with **autism spectrum disorders (ASD).** A disability is defined by the ADA as "...a physical or mental impairment which substantially limits one or more major life activities. . ." These are significant, ongoing conditions of more than 6 mos. duration rather than temporary or situational difficulties.

Disability Services assists students with disabilities by:

- Establishing eligibility for accommodations
- Identifying and overseeing the provision of reasonable accommodations.

Disability Services does not perform evaluations for students with ASD and the responsibility to pay for such evaluations is that of the student.

STUDENT, PLEASE COMPLETE THE SECTION BELOW:

Student's name _____ **Student's Date of Birth**_____

I _____ **give permission for the release of information to**
(Signature of student)
Disability Services for the purpose of determining academic accommodations.

_____

PROFESSIONAL, PLEASE COMPLETE ALL ITEMS BELOW:

DSM-V Diagnoses *(Please provide both code and descriptor)***:**
Primary:_____

Secondary (list all):_____

_____

Date of Diagnosis:_____/_____/_____

Initial visit with this provider: ____/____/____

Last appointment with this provider: ____/____/____

Basis on which Diagnosis was made (*check all that apply)*

□ Psycho-educational or neuropsychological assessment (please attach report)
□ Psychological Assessment (please attach report)
□ Standardized rating scales (please attach report)
□ Structured or unstructured interviews with student
□ Structured or unstructured interviews with other relevant persons (*e.g. parent, therapist, teacher*)
□ Behavioral observations
□ Developmental history
□ Medical history
□ Other (*Please specify*): _____

Clinical Manifestations/Symptoms: Please provide information regarding the student's current presenting symptoms with regard to the following; for each symptom indicate impact: none, mild, moderate, severe:

Social interaction, reciprocal verbal communication, shared emotions and affect	
Understanding nonverbal communication/cues	
Restricted, repetitive, or unusual patterns of motor behavior. i.e., stereotypic	
Inflexible adherence to routines	
Hyper or hypo reactivity to sensory input	
Executive Function	

Implications for Educational Success/Major Life Activities (REQUIRED):
Please check which of the major life activities below pose a substantial limitation because of the diagnosis.
Substantial limitation *is defined as a "significant restriction in the condition, manner, or duration in which a major life activity is performed compared to most people."*

☐ Concentration *****
☐ Memory *****
☐ Cognitive functioning *****
☐ Processing speed*****
☐ Communication
☐ Complex/abstract thinking
☐ Making and keeping appointments
☐ Managing external distraction
☐ Managing internal distraction
☐ Meeting deadlines
☐ Motor skills
☐ Stress management
☐ Task persistence
☐ Task organization/ prioritization
☐ Time management
☐ Other: _____
☐ Other: _____

***Note: Appropriate psychometric data (psychoeducational or neuropsychological eval.) should be attached for these areas of limitation.**

Please describe how each functional limitation will affect the individual's ability to participate fully in the post-secondary environment _____

_____

_____

Have you any recommendations regarding accommodations to equalize this student's educational opportunities at the post-secondary level? Each recommended accommodation must include description of a clear nexus to one or more functional impairments. (*Disability Services will make the final determinations regarding appropriate accommodations.)*

_____

_____

Is this student currently on medication that may impact his or her performance in the educational setting?

Yes _____ No____ If yes, please explain: _____

_____

Other comment: _____

_____

Please attach any other information relevant to this student's social and academic adjustment at the College

_____

Please note that Disability Services will make all final determinations of reasonable accommodations.

Signature of diagnostic practitioner_____Date_____

Type of License _____ State of License and No._____

Print name and title:_____

Address: _____

Telephone: _____Fax:_____ Email:_____

This form will be uploaded by the student to be sent to our office VIA a Secure File Transfer link. If you wish to send a copy to the Office of Disability Services, please use our Secure File Transfer link (https://sft.mc3.edu/filedrop/disabilities) or fax 215-619-7174. If faxed, please include a cover sheet with student's name and birthdate.

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