CONCORDIA UNIVERSITY TEXAS

OFFICE OF ACCESSIBILITY SERVICES

# Registration Guide

# How to Register for Accessibility Services

**Welcome Tornado!** Your adventure of faith, learning, and life-changing experiences is about to begin!

The team in the Office of Accessibility Services will help guide you through the registration process and advocate for your needs as a student.

## Who is Eligible?

Under the ADA Amendments Act of 2008 and Section 504 of the Rehabilitation Act of 1973, individuals with disabilities are protected from discrimination and may be entitled to reasonable accommodations. Students at Concordia University Texas are responsible for self-identifying their disability to the Office of Accessibility Services (OAS) with the necessary documentation. Once eligibility has been verified, the OAS will coordinate with students, faculty, and staff to arrange services and accommodations to ensure equal access to our educational programming and activities.

## How do I Register?

Students should complete the Registration Form on the Concordia University Texas website. Supporting documentation should be attached during registration so the OAS can better understand the functional impacts of the disability on the educational setting. All documentation submitted should be current and dated within 3 years of submission. If a student needs to request current documentation from a licensed provider he or she is encouraged to send the OAS Medical Verification Form and/or the OAS Mental Health Verification Form depending on their disability classification. A letter from a treating provider will be considered, but will not be guaranteed as a sole source of verification.

Helpful Types of Documentation:

- 504, IEP, or MTSS Plan from High School
- Medical Records
- Diagnostic Assessments
- OAS Medical Verification Form
- OAS Mental Health Verification Form

## How do I Register? (continued)

Once the OAS has received and reviewed all necessary information, the Director of Accessibility Services will reach out via email to the student's ctx.edu email account or by phone to schedule a meeting to discuss the accommodation request. Generally, this meeting's outcome will be a written agreement of services and accommodations offered by the university or reasons for denying the request.

Incoming freshman and transfer students are encouraged to reach out to the OAS before beginning classes so that there is ample time to arrange all needed accommodations. This also provides time in case additional documentation is needed to verify eligibility.

## Review of Registration Steps

1. Complete the Registration Form with current supporting documentation.
   *(Medical Records, School Records, Forms Provided by the OAS, etc.)*
2. Watch your ctx.edu email for communication from the OAS about your request.
   *(Request for more information or to schedule a meeting)*
3. Meet with the Office of Accessibility Services.
4. Start or continue your academic adventure at CTX!
5. Stay connected with the OAS about your academic needs each semester you are at CTX.

## Why Could My Request Be Denied?

Concordia University Texas reserves the right to deny services or accommodations if the student has not established a reasonable connection between his/her disability and the need for an accommodation. If the documentation provided by a student does not support the existence of a disability or the need for an accommodation, the student will be so advised. Students will be given the opportunity to supplement the initial documentation with further information from a specialist in their disability. The university is not required to provide an accommodation that compromises the essential requirements of a course or program, imposes an undue administrative or financial burden based on the university's overall institutional budget, or poses a direct threat to the health or safety of others.

## Can I Appeal?

Concordia University is committed to providing reasonable accommodations to qualified individuals with disabilities and to protecting students with disabilities from discrimination or retaliation. An appeal procedure is available for students who believe that they have not received reasonable accommodations and services or have been discriminated against. The OAS works with students and faculty to set up reasonable accommodations and to resolve any complaints about accommodations that may arise. A student who disagrees with a determination of eligibility or accommodation offerings is encouraged to meet first with the Director of Accessibility Services to resolve the matter.

If a resolution cannot be reached between the student and the Director of Accessibility Services, the complaint may be escalated to university leadership. The Provost/Executive Vice President at Concordia University Texas is designated as the Section 504/ADA Compliance Officer and will handle formal disability-related complaints from students. Written complaints should contain the student's name and address and a description of the problem or concern. The complaint should be filed within thirty (30) days of the student becoming aware of the problem or concern, and submitted to:

*Kristi Kirk, Provost/Executive Vice President*
*Concordia University Texas*
*11400 Concordia University Dr.*
*Austin, Texas 78726*

The Provost/Executive Vice President will meet with the student, other university officials or other interested parties to investigate the complaint. This investigation shall be informal, but thorough, affording all interested persons an opportunity to submit evidence relevant to the complaint. Within thirty (30) days a written determination of the validity of the complaint and a description of the resolution, if any, will be issued by the Provost/Executive Vice President and a copy forwarded to the student.

A complaint may also be filed with:

*Office of Civil Rights, U.S. Department of Education*
*400 Maryland Avenue, S.W.*
*Washington, D.C. 20202-1100*
*(800) 421-3481* ***TTD: (877) 521-2172*** *OCR@ed.gov*

**Office of Accessibility Services**
11400 Concordia University Dr.
Austin, TX 78726
512.313.5031

# Request for Accessibility Services Verification Form:

## *Physical or Medical Disabilities*

Under the ADA Amendments Act of 2008 and Section 504 of the Rehabilitation Act of 1973, individuals with disabilities are protected from discrimination and may be entitled to reasonable accommodations. Concordia University Texas' Office of Accessibility Services (OAS) works with students, healthcare providers, and faculty and staff to arrange services and accommodations to ensure equal access to educational programming and activities. To coordinate these services, current and comprehensive medical documentation from a licensed healthcare provider, who is not related to the student, is required to understand the scope and severity of the disability. Federal disability laws classify a disability as an impairment that substantially limits one or more major life functions; such as walking, seeing, hearing, breathing, eating, caring for oneself, performing manual tasks, and working. OAS will make all determinations on the eligibility for accessibility services and grant the appropriate accommodations and/or auxiliary aids to achieve the goal of equal access. The consultation given by healthcare providers on the accessibility recommendations in the post-secondary education setting is valued by the OAS. Additional documentation may be requested.

***This box is to be completed by the student.***

Student's Full Name: _____

Student's ID Number: B00_____

I, _____, authorize my healthcare provider below to release to Concordia University Texas' Accessibility Services the relevant medical information requested on this form for the purpose of determining appropriate accommodations for my permanent or temporary disability while a student at Concordia University Texas.

Student's Signature: _____ Date:_____

***The rest of the form is to be completed by the healthcare provider.***

*All items are required. Please print legibly. Include additional pages, if necessary.*

Provider's Name: _____ Medical Specialty:_____

Practice Name: _____ License/Certification #: _____

Practice Address: _____

Practice Phone Number:_____ Practice Fax:_____

# Medical History Documentation

Student's Name:_____ DOB:_____

Diagnosis *[Use additional forms for other Dx(s)]*:_____

Date of Dx:_____ Severity of Condition: ☐Mild ☐Moderate ☐Severe ☐In Remission

Please describe the symptoms of this disability, when in an active state, including frequency and duration, if applicable: _____

_____

_____

Current treatment plan and/or medication(s): _____

_____

Functional limitation(s) and/or impact caused by this disability, or its treatment, on the daily living of this student: _____

_____

_____

Recommendations for disability management within the post-secondary school setting:
*[Must be clearly linked to the functional limitation(s)/impact.]*

_____

_____

_____

Anticipated prognosis and planned medical follow-up appointments: _____

_____

Provider's Signature: _____ Date: _____

Provider's Printed Name:_____

CONCORDIA UNIVERSITY TEXAS

**Office of Accessibility Services**
11400 Concordia University Dr.
Austin, TX 78726
512.313.5031

# Request for Accessibility Services Verification Form:

*Mental Health or Cognitive Disabilities*

Under the ADA Amendments Act of 2008 and Section 504 of the Rehabilitation Act of 1973, individuals with disabilities are protected from discrimination and may be entitled to reasonable accommodations. These laws define a disability as a mental or physical impairment that substantially limits one or more daily life activities. Concordia University Texas' Office of Accessibility Services (OAS) works with students, healthcare providers, and faculty and staff to arrange services and accommodations to ensure equal access to educational programming and activities. To coordinate these services, current and comprehensive medical documentation from a licensed healthcare provider, who is not related to the student, is required to understand the scope and severity of the disability. OAS will make all determinations on the eligibility for accessibility services and grant the appropriate accommodations and/or auxiliary aids to achieve the goal of equal access. The consultation given by healthcare providers on the accessibility recommendations in the post-secondary education setting is valued by OAS. Additional documentation may be requested.

***This box is to be completed by the student.***

Student's Full Name: _____

Student's ID Number: B00_____

I, _____, authorize my healthcare provider below to release to Concordia University Texas' Accessibility Services the relevant medical information requested on this form for the purpose of determining appropriate accommodations for my permanent or temporary disability while a student at Concordia University Texas.

Student's Signature: _____ Date:_____

***The rest of the form is to be completed by the healthcare provider.***

*All items are required. Please print legibly. Include additional pages, if necessary.*

Provider's Name: _____ Medical Specialty:_____

Practice Name: _____ License/Certification #: _____

Practice Address: _____

Practice Phone Number:_____ Practice Fax:_____

# Mental Health History Documentation

Student's Name:_____ DOB:_____

## Diagnosis

DSM-5 Diagnosis/Diagnoses [or ICD-10 code(s)]:_____

_____

_____

Are there any pending diagnoses? _____

_____

Date of Dx:_____ Date of First Contact:_____

Date of Last Contact:_____ Frequency of Contact:_____

Have you consulted with any other medical professionals? ☐Yes ☐No

If yes, please provide the name(s) and the date(s) of contact:_____

_____

In addition to the DSM-5 diagnostic criteria, what other data was collected to assist your arrival at the diagnosis?

- ☐Behavioral Observations
- ☐Developmental History
- ☐Rating Scales (Beck Depression Scale, etc.)
- ☐Medical History
- ☐Structured or Unstructured clinical interview with the student
- ☐Interviews with others (parents, teachers, spouse, significant other)
- ☐Neuropsychological or psycho-educational testing, etc. (Dates:_____)
- ☐Other: _____

What methods/tools were utilized to assess functional limitations? Please list or attach documentation.

_____

_____

_____

## Relevant History

Are you prescribing this student take any medications currently?

☐Yes ☐No ☐Not the prescribing physician

If yes, please describe the current treatment plan and the impact of the medication on the student's ability to participate in the educational setting._____

_____

Has the student ever been hospitalized, received in-patient care, or harmed themselves or others as a part of this diagnosis?

☐Yes ☐No

If yes, please provide the dates and further details._____

_____

Is there evidence of previous treatment by a healthcare professional?

☐Yes ☐No

If yes, please explain your reasoning._____

_____

## Symptom Assessment

Describe how the student is substantially limited by the symptoms of their diagnosis in their daily life. (See the following pages for a list, if needed)_____

_____

_____

_____

_____

Describe how the student will face substantial limitations in the post-secondary setting.

_____

_____

_____

## Symptom Assessment (continued)

Please rate the frequency, duration, and severity of the ***relevant symptoms*** as related to the diagnosis.

**Frequency Scale**: How frequently do limitations occur?

**0**=Never **1**=Rarely **2**=Intermittently **3**=Frequently

**Duration Scale**: How long has the student experienced these limitations?

**1**=Recent/Acute Onset **2**=Months **3**=More than 1 Year

| Mental Health Symptom | Frequency Scale 0-3 *(see info above)* | Duration Scale 1-3 *(see info above)* | Severity | | | Comments *(Use back of the form for more space)* |
|---|---|---|---|---|---|---|
| | | | Mild | Moderate | Severe | |
| Compulsive Behaviors | | | | | | |
| Impulsive Behaviors | | | | | | |
| Obsessive Thoughts | | | | | | |
| Depressed Mood | | | | | | |
| Disordered Eating | | | | | | |
| Fatigue/Loss of Energy | | | | | | |
| Hypomania | | | | | | |
| Racing Thoughts | | | | | | |
| Self-Injurious Behavior | | | | | | |
| Suicidal Ideation | | | | | | |
| Suicide Attempts | | | | | | |
| Panic Attacks | | | | | | |
| Phobia, *Specify Below:* _____ | | | | | | |
| Anxious Mood | | | | | | |
| Unable to Leave House | | | | | | |
| Delusions | | | | | | |
| Hallucinations | | | | | | |
| Other, *Specify Below:* _____ | | | | | | |
| Other, *Specify Below:* _____ | | | | | | |

## Symptom Assessment (continued)

Please rate the frequency, duration, and severity of the ***relevant symptoms*** as related to the diagnosis.

**Frequency Scale**: How frequently do limitations occur?

**0**=Never **1**=Rarely **2**=Intermittently **3**=Frequently

**Duration Scale**: How long has the student experienced these limitations?

**1**=Recent/Acute Onset **2**=Months **3**=More than 1 Year

| Physiological Symptom | Frequency Scale 0-3 *(see info above)* | Duration Scale 1-3 *(see info above)* | Severity | | | Comments *(Use back of the form for more space)* |
|---|---|---|---|---|---|---|
| | | | Mild | Moderate | Severe | |
| Dizziness | | | | | | |
| Fainting | | | | | | |
| Racing Heart | | | | | | |
| Migraines/Headaches | | | | | | |
| Nausea | | | | | | |
| G.I. Distress | | | | | | |
| Shortness of Breath | | | | | | |
| Chest Pain | | | | | | |
| Other, *Specify Below:* _____ | | | | | | |
| Other, *Specify Below:* _____ | | | | | | |

## Functional Impact Assessment (Post-secondary Setting)

Please rate the frequency, duration, and severity of the ***relevant symptoms*** as related to the diagnosis.

**Frequency Scale**: How frequently do limitations occur?

**0**=Never **1**=Rarely **2**=Intermittently **3**=Frequently

**Duration Scale**: How long has the student experienced these limitations?

**1**=Recent/Acute Onset **2**=Months **3**=More than 1 Year

| Major Life Activity | Frequency Scale 0-3 *(see info above)* | Duration Scale 1-3 *(see info above)* | Severity | | | Comments *(Use back of the form for more space)* |
|---|---|---|---|---|---|---|
| | | | Mild | Moderate | Severe | |
| Initiating Activities | | | | | | |
| Concentration | | | | | | |
| Following Directions | | | | | | |
| Memorization | | | | | | |
| Persistence | | | | | | |
| Processing Speed | | | | | | |
| Organizational Skills | | | | | | |
| Sustained Reading | | | | | | |
| Sustained Writing | | | | | | |
| Problem Solving | | | | | | |
| Listening | | | | | | |
| Sitting | | | | | | |
| Speaking | | | | | | |
| Interacting with Others | | | | | | |
| Sleeping | | | | | | |
| Self-Care | | | | | | |
| Other, *Specify Below:* _____ | | | | | | |
| Other, *Specify Below:* _____ | | | | | | |

## Anticipated Progress/Prognosis

What is the anticipated prognosis of the diagnosis over the course of the student's lifetime?

_____

_____

What progress have you seen while the student has been under your care?

_____

_____

Please provide any information on environmental triggers or cyclical patterns observed during the student's treatment. _____

_____

## Recommended Accommodations

Please provide recommendations for disability management within the post-secondary setting.

(*Each recommendation must be clearly linked to a functional limitation or impact.)*

_____

_____

_____

_____

_____

## Provider's Signature

Provider's Signature: _____ Date: _____

Provider's Printed Name:_____