OFFICE OF DISABILITY SUPPORT SERVICES

APPLICATION FOR SUPPORT SERVICES

Name: _____ _____ _____ Student ID #: _____
First M.I. Last

Local Address: _____

City: _____ State: _____ Zip Code: _____

Cell Phone: (_____) - _____ - _____ Home Phone: (_____) - _____ - _____

E-mail _____

Are you a client of the Department of Rehabilitation? ☐ Yes | ☐ No

If yes, name of counselor: _____ Office: _____

Are you a client of the Veteran's Administration Rehabilitation? ☐ Yes | ☐ No

Disability is (check one): ☐ Permanent | ☐ Temporary

Please check the following items that directly apply to your situation:

Visual Impairment

☐ Partial Sight

☐ Blindness

Communication

☐ Deafness

☐ Hard of Hearing

☐ Speech Limitation

Functional Limitation

☐ Diabetes

☐ Epilepsy

☐ Other

Mobility

☐ Amputation

☐ Arthritis

☐ Cardiovascular

☐ Cerebral Palsy

☐ Hemophilia

☐ Multiple Sclerosis

☐ Post Polio

☐ Respiratory

☐ Spinal Cord Injury

☐ Other

Other:

☐ Emotional

☐ Autism Spectrum Disorder (ASD)

☐ Specific Learning Disability

☐ **Other Health:**

_____

_____

_____

_____

_____

Do you use any of the following?

- ☐ Manual Wheelchair
- ☐ Electric Wheelchair
- ☐ Crutches/Cane/Walker/Braces
- ☐ Respiratory Aids
- ☐ Hearing Aids
- ☐ Pacemaker
- ☐ Service Animal
- ☐ White Cane
- ☐ Other: _____

What are your sources of income?

- ☐ Family Supported
- ☐ Self-Supported
- ☐ Aid to Potentially Self-Supporting Blind
- ☐ AFDC
- ☐ Financial Aid (CSUSM)
- ☐ General Assistance
- ☐ SSI (Gold Check)
- ☐ SSDI (Green Check)
- ☐ Veteran's Benefits
- ☐ Other: _____

What reasonable accommodation(s) are you requesting (i.e. testing accommodations, large print material, sign language interpreters, priority registration)?

_____

_____

_____

_____

Please sign and date below:

_____ _____

Signature Date