



Accessibility Services Office
Center for Academic Success
1060 Bishop Street, Suite 602 (LB Bldg)
Honolulu, Hawai'i 96813-2882
Telephone: (808)544-1197
Fax: (808) 544-1170
Email: disabilityresources@hpu.edu

Dear Healthcare Professional:

Your patient/client, _____, wishes to register with Accessibility Services at Hawaii Pacific University. The Accessibility Services office provides academic services and accommodations for students with disabilities in accordance with Section 504 of the Rehabilitation Act of 1973 and with the Americans with Disabilities Act (ADA) of 1990 as amended in 2008. The ADA states the following:

The term "disability" means with respect to an individual –

- A. A physical or mental impairment that substantially limits one or more major life activities of such individual;
- B. A record of such an impairment; or
- C. Being regarded as having such an impairment,

In order for a student to be considered eligible to receive academic accommodations, documentation must show functional limitations that impact the individual in an academic setting. Individuals requesting accommodations must disclose the nature of their impairment and provide recent documentation that verifies their condition. When providing information necessary to evaluate eligibility for academic accommodations, please adhere to the following:

The healthcare professional(s) conducting the assessment and/or making the diagnosis must be qualified to do so. These professionals are generally trained, certified, or licensed psychologists or members of a medical specialty.

Complete the attached form as thoroughly as possible. Inadequate information, incomplete answers, and/or illegible handwriting may delay the eligibility review process by necessitating follow-up contact for clarification. This form can also be completed by typing information into the fillable PDF form available on our website at XXX.

The healthcare professional should attach any reports that provide related information (e.g. psycho-educational testing, neuropsychological test results, medical evaluation results, etc.). If a comprehensive diagnostic report is available that provides the requested information, copies of that report can be submitted for documentation instead of this form. Please do not provide case notes or rating scales without a narrative that explains the results.

After completing the attached form, sign it and complete the Healthcare Provider Information section on the last page. The completed form can be mailed to our office, or emailed as a PDF to disabilityresources@hpu.edu. Information provided will not become part of a student's educational records, but it will be kept in the student's file within the Disability Resources Office where it will be held strictly confidential. This form may be released to the student at his/her request. In addition to the requested information, please attach any additional information that would be relevant to the student's academic adjustment.

If you have questions regarding this form or the Accessibility Services process, please call our office at 808.544.1197 or email disabilityresources@hpu.edu. Thank you for your assistance.



DISABILITY DETERMINATION FORM

**Student Information
(Please Print Legibly or Type)**

Name (Last, First, Middle): _____

Date of Birth: _____ Student ID: @ _____

Status: Current Student Transfer Student Prospective Student

Phone: _(____)_____-_____ Cell Phone:_(____)_____-_____

Address (Street, City, State, Zip Code): _____

HPU Email Address: _____ @my.hpu.edu

Personal Email Address: _____

To Be Completed by Healthcare Professional

Date last seen: _____

Impairments/Diagnosis (If applicable, include date of diagnosis and DSM-5/ICD-10 codes):

Relevant patient/Client history:

Additional psychosocial and contextual factors:



How was the impairment/diagnosed determined?

- Structured or unstructured interviews with the student
- Interviews with other persons
- Behavioral observations
- Developmental History
- Educational History
- Medical History
- Neuropsychological testing (dates of testing) _____
- Psycho-educational testing (dates of testing) _____
- Standardized or non-standardized rating scales
- Other (please specify) _____

How would you categorized this condition in terms of severity? Please check only one and explain below:

- Minimal Moderate Severe Residual/Remission Other: _____

The condition is: Stable Prone to exacerbation Other: _____

Duration of impairment/diagnosis is: Permanent Temporary

Note Duration: _____ **Or** Re-Evaluation Date: _____

Indicate major life activities that are affected because of the impairment and severity of those limitations. This list is not exhaustive and additional life activities can be added at the bottom of this chart.

Life Activity	Negligible	Moderate	Substantial	Don't Know	N/A
Breathing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Concentrating	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eating	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Emotional Processes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hearing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Keeping Appointments	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Learning	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lifting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Managing External Distractions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Managing Internal Distractions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Manual Tasks	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Memory	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Organization	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Regular Attendance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Seeing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>



Life Activity	Negligible	Moderate	Substantial	Don't Know	N/A
Self Care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sitting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sleeping	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Social Interactions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Speaking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stamina	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stress Management	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Studying	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Taking Notes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Taking Tests	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Thinking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Walking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Writing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Specifically describe to what extent the impairment impacts the student's ability to function academically and in a college environment addressing any items endorsed on the previous page:

If applicable, list any medications currently prescribed and how they have an impact on the student's learning. Please also include any side effects and impact on academic performance:

Is this student currently receiving therapy or counseling? Yes No Not Sure

Please indicate specific recommendations regarding academic accommodations for this student and a rationale as to why these accommodations/adjustments/services are warranted based on the student's functional limitations. Indicate why the accommodations are necessary.



Hawaii Pacific University

Office of Accessibility Service

If current treatments (e.g., medication, therapy) are successful, please state the reason that the above academic adjustments, auxiliary aids, and/or services are necessary.

Is the student able, with reasonable accommodations, to take a full course load of 12 college credits?

- Yes No (Please explain below)

This student's diagnosis is significant enough to severely impair his/her ability to learn and express that learning within a college environment.

- I Agree with this statement I Disagree with this statement

I understand that the information provided will become part of the student record subject to the Federal Family Education Rights and Privacy Act of 1974 and may be released to the student on their written request.

Healthcare Professional Signature: _____ Date: _____

Healthcare Professional Name (Print) _____

Title: _____

Address: _____

Phone _(_____)_- _____ Fax Number: _(_____)_- _____

Email Address: _____

Name of Person Completing Form: _____ Date: _____

Professional of Affiliation/Title: _____

Important: After documentation is reviewed, ASO will send an email notification to the student's HPU email account acknowledging receipt of documentation and eligibility status.