



Disability Services Intake Form

PLEASE PRINT

Name: _____ **Date:** _____

Date of Birth: _____ **SSN:** _____ **or EMPLID:** _____

Mailing Address:

Street and Number _____ City _____ State _____ Zip Code _____

E-mail: _____

Telephone: Day _____ Evening _____ Other _____

Currently attending ESCC: Yes _____ No _____

Do you plan to transfer? Yes _____ No _____ Where? _____

Employment:

Currently Employed: Yes _____ No _____ If yes, hours per week: _____

Type of Work: _____

Educational Goals:

- ___ Take a few courses that interest me
- ___ Complete a certificate at ESCC
- ___ Complete a 2-year applied science degree at ESCC
- ___ Complete a 2-year transfer degree at ESCC and transfer to a four-year college
- ___ Take transfer classes and transfer after one year
- ___ Improve basic skills in reading, writing, math, etc.
- ___ Other _____

If seeking a certificate or degree, what is your major? _____

What job or career fields are you considering: _____

Special Interests or Hobbies: _____

Have you registered to vote: Yes _____ No _____

Disability Information: Check all that apply

- | | |
|-------------------------------|---------------------------|
| _____ Blind/Visually Impaired | _____ Cerebral Palsy |
| _____ Deaf or Hard of Hearing | _____ Learning Disability |
| _____ Mobility Impairment | _____ Speech Impairment |
| _____ Brain Injury | _____ Other _____ |



Please describe below how your disability impacts your educational progress:

Three horizontal lines for describing disability impact.

Please circle any services or accommodations listed below that you received in high school or college.

Services:

- Speech therapy
Vision training or prism lenses
Certification for books on tape
Large print textbooks
Braille textbooks
Medication for ADHD
Psychotherapy
Sign language interpreter
Personal assistant

Accommodations:

- Use of tape recorder
Extended time on tests or assignments
Provision of private testing room
Special seating arrangement
Special chair or desk/table requirements
Special lighting
Adaptive technology
Other

Horizontal line for additional accommodations.

Are you a client with any Virginia State Agency?

(DRS, DBVI, VDDHH, Mental Health) Yes _____ No _____

Please list: followed by three horizontal lines for listing agencies.

Name of caseworker or counselor:

Horizontal line for caseworker or counselor name.

The ESCC Disabilities Coordinator has my written permission to discuss my accommodations, as necessary, with ESCC faculty and other appropriate college professionals, as necessary. A separate "Release of Information Form" must be obtained to discuss my accommodations with any agency, office, department or other service provider including a counselor, caseworker, physician, or psychiatrist.

Student Signature: _____

Date: _____