ACCESSIBILITY RESOURCE CENTER

DOCUMENTATION GUIDELINES

Students requesting services from Accessibility Resource Center (ARC) are required to submit documentation of a disability to verify eligibility under the Americans with Disabilities Act Amendments Act (ADAAA), Section 504 of the Rehabilitation Act of 1973, and the University of New Mexico Policy 2310. ADAAA defines a disability as a substantial limitation of a major life function. The diagnostic report must document a disability. It is important to recognize that academic adjustment needs can change over time and are not always identified through the initial diagnostic process. Conversely, a prior history of accommodation, without demonstration of current need, does not in and of itself warrant the provision of a like accommodation.

Submission of documentation is not the same as the request for services. Request for services and/or reasonable accommodations *must be initiated by the student* once he/she is admitted to the University of New Mexico (UNM). The applicant or student must schedule an intake appointment with ARC so that support services and reasonable accommodations may be discussed. Applicants to, or students in, the UNM School of Medicine and the Colleges of Nursing and Pharmacy should contact the UNM School of Medicine Programs' liaison for information on requesting academic adjustments. Applicants to, or students in, the UNM Law School should notify the Law School Assistant Dean for Student Services as well as ARC. Documentation will be reviewed by the documentation committee specific to the applicant or student's program of study prior to the appointment. Reasonable accommodations cannot be implemented until the student's documentation is complete. ARC is responsible for the determination of reasonable accommodations.

Please note programs of study may require students to take licensing or certification exams prior to graduation. Determination of academic adjustments is made by the national licensing or certification body not UNM. It is important to research their documentation requirements early in your program as it may be necessary to seek a reevaluation at your expense prior to the request for accommodations from the national testing body.

If documentation does not meet the preferences listed below, please submit it for review. The submission will be used to determine what if any if additional documentation is needed to meet the documentation requirements. If documentation is outdated or incomplete, students may be asked to provide an update to their information.

GUIDELINES FOR LEARNING AND COMMUNICATION DISABILITIES

A copy of the comprehensive psycho-educational report must be provided to the UNM, ARC in order for the student to be eligible for accommodations and/or modifications. Documentation within the last three years for high school age students entering UNM immediately upon graduation and five years for nontraditional students is preferred. Older documentation will be taken into consideration by the committee.

School psychologists, clinical psychologists, neuropsychologists, psychiatrists, neuropsychiatrists, and other qualified medical doctors with experience and expertise in the area related to the student's disability should make the diagnosis.

The evaluation must include:

- A clear diagnosis generally based on DSM-IV-TR or DSM-V criteria;
- Testing must be comprehensive;
- Minimally, the domains to be addressed must include, but are not limited to
    - A diagnostic interview,
    - A complete psycho-educational or neuropsychological evaluation;
- The following areas should be assessed
    - Aptitude - intellectual assessments,
    - Achievement - current levels of academic functioning,
    - Information Processing - specific areas of information processing;
- An interpretative summary.

OR

A letter from a qualified professional including ***all of the general guidelines listed above*** providing substantial evidence of a prior diagnosis, accommodation, or classification, such as eligibility for a special education program.

OR

An eligibility letter from Department of Vocational Rehabilitation or Veteran Services.

All reports should be on letterhead, typed, dated, signed, and otherwise legible. The name, title, and professional credentials of the evaluator, including information about license or certification as well as area of specialization, employment, and state in which the individual practices must be clearly stated. Evaluators should not be related to the individual being assessed. Diagnoses written on prescription pads and/or parent's notes indicating a disability are not considered appropriate documentation. A nonspecific diagnoses, such as individual "learning styles," "learning differences," "academic problems," "attention problems," "mood

disorders," and "test difficulty/anxiety" in and of themselves do not constitute a disability.

The following ***supplemental information*** is useful, but not required. These pieces on their own are not usually considered complete, comprehensive documentation:

- A summary of performance [SOP]
- Information about Response to Intervention [RTI]
- Individualized Education Plan [IEP]
- Section 504 Accommodation Plan [504]

GUIDELINES FOR ATTENTION DEFICIT HYPERACTIVITY DISORDER (AD/HD)

While it is recognized that psychological testing alone does not justify an AD/HD diagnosis, such testing is considered an important part of establishing the impact of the disorder on learning and determining appropriate accommodations. It is also essential in determining the presence or absence of other conditions that frequently occur with the diagnosis, which may be of relevance in the classroom. Comprehensive psycho-educational or neuropsychological evaluations are strongly encouraged and may be required to support specific accommodation requests.

Clinical psychologists, neuropsychologists, psychiatrists, neuropsychiatrists, and other qualified medical doctors with experience and expertise in the area related to the student's disability should make the diagnosis. At a minimum, all documentation in support of an AD/HD diagnosis should include the following information:

- A clear diagnosis generally based on DSM-IV-TR or DSM-V criteria.
- A history of symptoms of the disorder.
- An explanation of the functional limitations.

This is most typically provided in a detailed psycho-educational report including:

- Cognitive testing; examples of instruments include:
    - Wechsler Adult Intelligence Scale (Revised or IV),
    - Woodcock Johnson Psychoeducational Battery Test of Cognitive Ability (Revised or III).
- A complete neuropsychological battery describing processing strengths and weaknesses.
- Achievement testing including test results from individual achievement measures in math, written expression, and if relevant, foreign language acquisition.

OR

Disability Verification Form

OR

An eligibility letter from Department of Vocational Rehabilitation or Veteran Services.

All reports should be on letterhead, typed, dated, signed, and otherwise legible. The name, title, and professional credentials of the evaluator, including information about license or certification as well as area of specialization, employment, and state in which the individual practices must be clearly stated. Evaluators should not be related to the individual being assessed. Diagnoses written on prescription pads and/or parent's notes indicating a disability are not considered appropriate documentation.

The following ***supplemental information*** is useful, but not required) in planning for accommodations. These pieces on their own cannot usually be considered complete, comprehensive documentation:

- A summary of performance [SOP]
- Information about Response to Intervention [RTI]
- Individualized Education Plan [IEP]
- Section 504 Accommodation Plan [504]

GUIDELINES FOR BRAIN INJURY (BI)

Students submitting documentation of physical and/or cognitive impairment related to a brain injury (e.g., head trauma, CVA's, tumors, other medical conditions) must submit evidence of a disabling condition with evidence of functional impairment in major life activities of relevance to the classroom.

Neurologists, clinical psychologists, neuropsychologists, psychiatrists, neuropsychiatrists, and other qualified medical doctors with experience and expertise in the area related to the student's disability should make the diagnosis.

Such documentation should include:

- Detailed background information.
- A comprehensive neuropsychological evaluation.
- Detailed information regarding residual physical or medical impairments.
- A specific diagnosis, as per DSM-IV-TR, DSM-V, ICD 9, or ICD 10.
- Suggested recommendations, modifications and/or accommodations.
- Additional documentation on comorbid physical or medical conditions.

OR

Disability Verification Form

OR

An eligibility letter from Department of Vocational Rehabilitation or Veteran Services.

All reports should be on letterhead, typed, dated, signed, and otherwise legible. The name, title, and professional credentials of the evaluator, including information about license or certification as well as area of specialization, employment, and state in which the individual practices must be clearly stated. Evaluators should not be related to the individual being assessed. Diagnoses written on prescription pads and/or parent's notes indicating a disability are not considered appropriate documentation.

The following ***supplemental information*** is useful, but not required. These pieces on their own are not usually considered complete, comprehensive documentation:

A summary of performance [SOP] Section 504 Accommodation Plan [504] Information about Response to Intervention [RTI] Individualized Education Plan [IEP]

GUIDELINES FOR A PSYCHOLOGICAL DISABILITY

Students submitting documentation of a psychological disability must submit evidence of a disabling condition with evidence of functional impairment in major life activities of relevance to the classroom. Accommodations are based on an assessment of the current nature and impact of your disability. Because psychiatric conditions may change over time, current evaluations are critical for providing reasonable accommodations. An evaluation within the last twelve (12) months is recommended. In addition, depending on the nature of the disability, evaluations may need to be updated on a semester-by-semester or yearly basis. Older documentation will be taken into consideration by the committee.

A formal assessment of your current psychiatric and health status, and a formal diagnosis of a disabling condition must be provided by a licensed treatment provider (e.g., psychologist, neuropsychologist, psychiatrist, neuorpsychiatrist, licensed counselor, psychologist, licensed social worker, and psychiatric nurse practitioner).

Documentation should include:

- Comprehensive evaluation.
- Evidence of significant limitations in the educational setting.
- Minimally, the evaluator must include
    - A diagnostic interview.
    - A DSM-IV-TR, DMS-V, ICD-9, or ICD-10.
    - The dates of evaluation and/or treatment.
    - The evaluation should include medical and medication history.
    - A description of current functional limitations in different settings.

- A description of the degree of impact of the diagnosed psychiatric disorder.

OR

Disability Verification Form

OR

An eligibility letter from Department of Vocational Rehabilitation or Veteran Services.

All reports should be on letterhead, typed, dated, signed, and otherwise legible. The name, title, and professional credentials of the evaluator, including information about license or certification as well as area of specialization, employment, and state in which the individual practices must be clearly stated. Diagnoses written on prescription pads and/or parent's notes indicating a disability are not considered appropriate documentation. Nonspecific diagnoses, such as "adjustment problems," "emotional difficulties," "mood disturbance," and/or "test difficulty/anxiety" in and of themselves do not constitute a disability.

The following ***supplemental information*** is useful, but not required. These pieces on their own are not usually considered complete, comprehensive documentation:

- A summary of performance [SOP]
- Information about Response to Intervention [RTI]
- Individualized Education Plan [IEP]
- Section 504 Accommodation Plan [504]

GUIDELINES FOR DOCUMENTING A PHYSICAL OR MEDICAL DISABILITY

A physician, surgeon, physical therapist, occupational therapist, or other medical specialist with experience and expertise in the area related to the student's disability, should make the diagnosis. The age of acceptable documentation is dependent upon the condition and the nature of the student's request for accommodations.
Disabilities that are sporadic or change over time may require more frequent evaluations.

Conditions may include, but are not limited to, mobility impairments, multiple sclerosis, cerebral palsy, chemical sensitivities, spinal cord injuries, cancer, AIDS, muscular dystrophy, spina bifida, diabetes, asthma, etc.

Documentation should include:

- A clear statement of diagnosis using ICD 9 or ICD 10.
- A summary of assessment procedures and evaluation instruments that have been.
- Information relating to treatment and its impact on the student's ability.
- Relevant information regarding any medication.
- A statement of the functional limitations on learning or other major life activity.
- Rationale for each recommended accommodation.

OR

Disability Verification Form

OR

An eligibility letter from Department of Vocational Rehabilitation or Veteran Services.

All reports should be on letterhead, typed, dated, signed, and otherwise legible. The name, title, and professional credentials of the evaluator, including information about license or certification as well as area of specialization, employment, and state in which the individual practices must be clearly stated. Evaluators should not be related to the individual being assessed. Diagnoses written on prescription pads and/or parent's notes indicating a disability are not considered appropriate documentation.

The following ***supplemental information*** is useful, but not required. These pieces on their own cannot usually be considered complete, comprehensive documentation:

Section 504 Accommodation Plan [504]

GUIDELINES FOR DOCUMENTING VISUAL IMPAIRMENTS

An ophthalmologist, optometrist or other qualified professional should make the diagnosis and complete the appropriate documentation. The age of acceptable documentation is dependent upon the nature of the condition and the student's request for accommodations. Visual disabilities of a changing nature may need to be documented more frequently.

Documentation should include:

- A clear statement of vision-related disability with supporting numerical description.
- Also include a statement as to whether the condition is progressive or stable.
- Include the following sections that are relevant to the individual

    - Eye Health
    - Visual Fields
    - Binocular Evaluation
    - Accommodative Skills
    - Oculomotor Skill
- A summary of assessment procedures and evaluation instruments that were used.
- Narrative or descriptive text providing both quantitative and qualitative information.
- Medical information relating to the student's needs and the impact.
- A statement of the functional impacts or limitations of the vision loss.
- Specific cognitive processing strengths, weaknesses, and deficits.
- Recommended accommodations.

OR

Disability Verification Form

OR

An eligibility letter from the New Mexico Commission for the Blind or Veteran Services.

All reports should be on letterhead, typed, dated, signed, and otherwise legible. The name, title, and professional credentials of the evaluator, including information about license or certification as well as area of specialization, employment, and state in which the individual practices must be clearly stated. Evaluators should not be related to the individual being assessed. Diagnoses written on prescription pads and/or parent's notes indicating a disability are not considered appropriate documentation.

The following ***supplemental information*** is useful, but not required. These pieces on their own cannot usually be considered complete, comprehensive documentation:

Section 504 Accommodation Plan [504]

GUIDELINES FOR DOCUMENTING DEAF AND HARD OF HEARING

A physician, audiologist, speech and hearing specialist or other qualified professional should make the diagnosis. The age of acceptable documentation is dependent upon the condition and the nature of the student's request for accommodations. Hearing loss of a changing nature may need to be documented more frequently.

Documentation should include:

- A clear statement of deafness or any degree of hearing loss with a current audiogram.
- Include the cause of hearing loss, on-set of hearing loss, and clinical diagnosis.
- A summary of assessment procedures and evaluation instruments used.
- Narrative summary.
- Medical information relating to the student's needs the status of hearing.
- A statement of the functional impacts or limitations of the hearing loss on learning.
- Specific cognitive processing strengths, weaknesses, and deficits.

OR

Disability Verification Form

OR

An eligibility letter from New Mexico Commission for the Deaf and Hard of Hearing or Veteran Services.

All reports should be on letterhead, typed, dated, signed, and otherwise legible. The name, title, and professional credentials of the evaluator, including information about license or certification as well as area of specialization, employment, and state in which the individual practices must be clearly stated. Evaluators should not be related to the individual being assessed. Diagnoses written on prescription pads and/or parent's notes indicating a disability are not considered appropriate documentation.

The following ***supplemental information*** is useful, but not required. These pieces on their own cannot usually be considered complete, comprehensive documentation:

Section 504 Accommodation Plan [504]