DSPS
Application for Services

CONFIDENTIAL

Saddleback College provides educational services and access for eligible students with documented disabilities who intend to pursue coursework at Saddleback College. A variety of programs and services are available which afford eligible students with disabilities the opportunity to participate fully in all aspects of college programs and activities through appropriate and reasonable accommodations. Completion of this form constitutes an agreement to apply for DSPS.

Today's date: _____

Student ID#: _____ ***Social Security Number:** _____

Name: _____
LAST FIRST M.I.

Home phone #: _____ **Cell phone #** _____

May we leave a confidential message at this number? Home #: Yes or No Cell #: Yes or No *(Please circle)*

Address: _____
NO. STREET CITY STATE ZIP

Email address: _____

Birthdate: _____
(MM / DD / YY)

Emergency contact: _____ **Telephone #:** _____

Disabilities/Health/Learning problems: _____

_____

What services do you wish to receive? _____

_____

Do you have a Dept. of Rehabilitation counselor? Yes_____ No_____

Name of Dept. of Rehabilitation counselor: _____

Please call me when I have an appointment in DSPS: Yes_____ No_____

Student Responsibilities:

1. I will provide DSPS with the information, documentation and/or forms (educational, psychological, medical, etc.) deemed necessary by DSPS to verify my disability(ies).
2. I will meet with a DSPS professional to complete a Student Educational Contract, and agree to meet with a DSPS counselor or specialist at least annually to update the Student Educational Contract.
3. I will utilize DSPS in a responsible manner. I understand that DSPS uses written service provision policies and procedures that must be adhered to for continuation of services.
4. I will comply with the Student Code of Conduct adopted by the college. (See www.saddleback.edu/media/pdf/handbook.pdf)

I understand that I must fulfill the requirements for participation in DSPS. I have received a copy or been given the DSPS web page address to obtain the DSPS student handbook and policy on suspension of services. I understand the consequences of failing to comply with the rules for responsible use of these services. I understand that I will be notified in writing before any action is taken to suspend services. By signing this application, I affirm that I understand and agree with the Student Responsibilities, and I will abide by them (see www.saddleback.edu/dsps).

_____
STUDENT SIGNATURE DATE

***** Pursuant to Section 7 of the Federal Privacy Act (Public Law 93-579; 5 U.S.C. § 552a, note), providing your social security number is voluntary. The Community College District uses the information requested on this form for the purpose of determining a student's eligibility to receive authorized services provided by the Disabled Student Programs & Services (DSPS) Program. Personal information recorded on this form will be kept confidential in order to protect against unauthorized disclosure. Portions of this information may be shared with the Chancellor's Office of the California Community Colleges or other state or federal agencies; however, disclosure to these parties is made in strict accordance with applicable statutes regarding confidentiality, including the Family Educational Rights and Privacy Act (20 U.S.C. 1232 (g)). The information on this form is being collected pursuant to California Education Code Sections 67310-67312, and 84850; and California Code of Regulations, Title 5, Section 56000 et seq.

For Office Use Only

Student Name _____ ID#_____

VERIFIED ELIGIBILITY

☐ Summer _____ ☐ Fall _____ ☐ Spring _____

P	S		P	S		P	S	
☐	☐	A.B.I.	☐	☐	HEARING	☐	☐	PSYCH
☐	☐	D.D.L.	☐	☐	MOBILITY	☐	☐	SPEECH
☐	☐	L.D.	☐	☐	VISUAL	☐	☐	OTHER

☐ Non Claimable

_____

CERTIFICATED SIGNATURE DATE

_____

CERTIFICATED SIGNATURE DATE

_____

CERTIFICATED SIGNATURE DATE

Comments:

P = PRIMARY

S = SECONDARY (more than 1 secondary is possible)

Application Processed by:_____