# Documentation Guidelines

Disability Services collaborates with students with documented disabilities to provide reasonable and appropriate accommodations that are individualized and based upon disability documentation, functional limitations, and a collaborative assessment of needs.

To be eligible for services, a student must provide current appropriate written documentation from a licensed and/or certified professional in the field concerning the specific diagnosis. Documentation must validate the presence of a disability as defined under Section 504 of the Rehabilitation Act of 1973 and the Americans with Disabilities Act Amendment Act 2008 (ADA-AA). The documentation should include an evaluation that clearly states what the impairment is and how the impairment impacts the student's ability to participate in the college's educational programs and services. Functional limitations and the relationship with the accommodation(s) requested should be clearly outlined. For more information on receiving accommodations see the Disability Services Procedures and the Rights and Responsibilities forms.

The general and disability specific guidelines that are listed below were developed to assist professional(s) in preparing the information needed to evaluate the student's request for accommodation(s).These guidelines are based upon current United States disability law (504, ADA-AA).

Please note: information provided by public and private special education programs (i.e. IEP, Social History, Special Education Eligibility) may be helpful but may not fully meet the Disability Services needs in terms of adequacy or currency of documentation. It is important to consult with Disability Services about the need for, and appropriateness of documentation. If there are any questions about documentation guidelines, individuals can contact Baker Disability Services at: disability_specialist@baker.edu.

## General Guidelines

*All documentation submitted to Disability Services must include the following information in addition to disability specific information listed on following pages.*

1. Credentials of the evaluator(s): Documentation must be provided by a licensed or otherwise properly credentialed professional who has undergone appropriate, comprehensive training and experience relevant to the student's diagnosis. (e.g., an orthopedic impairment might be documented by a physician, but not a licensed psychologist).

2. A diagnostic statement identifying the disability: Documentation must include both a diagnosis and a statement that describes how the condition was diagnosed, provides evidence on the functional impact, and details the typical progression or prognosis of the condition.

3. A description of the diagnostic methodology used: Documentation should include a description of the diagnostic criteria, evaluation methods, procedures, tests, and dates of administration, as well as a clinical narrative, observation, and specific results. If standardized tests were administered both the standard and percentile scores need to be provided in the report.

4. A description of current functional limitations: Information on how the disabling condition(s) currently impacts the individual provides useful information for both establishing a disability and identifying possible accommodations. A combination of the results of formal evaluation procedures, clinical narrative, and the individual's self-report is the most comprehensive approach to fully documenting impact. Documentation is expected to be thorough enough to demonstrate whether and how a major life activity is substantially limited by providing a clear sense of the severity, frequency and pervasiveness of the condition(s).

5. A description of the expected progression or stability of the disability: It is helpful when documentation provides information on expected changes in the functional impact of the disability over time and context. Information on the cyclical or episodic nature of the disability and known or suspected environmental triggers to episodes provides opportunities to anticipate and plan for varying functional impacts.

6. A description of current and past accommodations, services, and/or medications: Documentation will include a description of current medications, auxiliary aids, assistive devices, support services, and accommodations, including their effectiveness in ameliorating functional impacts of the disability. A discussion of any significant side effects from current medications or services that may impact physical, perceptual, behavioral or cognitive performance is helpful when included in the report. While accommodations provided in another setting are not binding on the current institution, they may provide insight in making current decisions.

## Disability Specific Guidelines

*If you are requesting accommodations based on multiple disabilities, documentation for each disability is required. Professionals must either thoroughly complete the disability verification form or provide a detailed report addressing the specific disability guidelines.*

### Attention Deficit/Hyperactivity Disorders

- A clear diagnostic statement from the current version of the DSM or ICDM, including pertinent history of ADHD symptoms demonstrated during childhood.
- Description of current ADHD symptoms across multiple settings.
- Exclusion of differential diagnoses (i.e. LD or mental health disorders).
- Treatment information including current medication.
- Impact of condition in a college environment.
- Documentation should be no older than three years.
- If a psycho-educational evaluation is provided it should include standardized measures of cognitive development, academic achievement, information processing, and adaptive/emotional functioning, in addition to measures of attention (TOVA, IVA, TEA). Both standard and percentile scores should be provided.

### Learning Disabilities

- Documentation should be in the form of a written report based on a current and comprehensive psycho-educational or neuropsychological evaluation.
- Psycho-educational evaluation should include standardized measures of cognitive development, academic achievement, information processing, and adaptive/emotional functioning. Both standard and percentile scores need to be provided.
- Diagnosis must be made by a qualified professional who is trained, licensed or certified in psycho-educational assessment and diagnosis.
- Testing should be done at age 16 or later with an adult-normed test, preferably within 5 years.

## Autism Spectrum Disorders

- Documentation should be in the form of a current and comprehensive diagnostic report from a qualified professional which includes specific information in areas of functional impairment.
- In the diagnostic reports a narrative concerning behavioral, social, and communication issues should be addressed.
- Documentation needs to be based on an assessment completed at age 16 or older. If the documentation is older than 5 years an update is required.

## Traumatic Brain Injuries

- Documentation should be in the form of a current and comprehensive diagnostic report, that is no older than two years, from a qualified professional which includes specific information in areas of functional impairment.

## Psychological Impairments

- Documentation should be in the form of a comprehensive completed Baker Verification Form or a comprehensive report that is no older than two years, depending on the severity of the condition.
- Documentation should include all the criteria written above in General Guidelines.
- There must be a specific diagnosis which is consistent with the diagnostic criteria found in the current version of the DSM or ICDM.
- Diagnosis must be made by a licensed psychologist, psychiatrist, or other practitioner qualified to make mental health diagnoses.

## Medical Impairments & Physical Impairments

- Documentation should be in the form of a current and comprehensive medical report, practitioner's letter, or using the Verification Form (Currency of the documentation will be based on the nature of the disability).
- Documentation should include all criteria written above in General Guidelines.
- Doctor's prescription pad notes will not be accepted.
- Diagnosis must be made by a practitioner qualified to make the diagnosis.

## Deaf/Hard of Hearing

- Documentation should be in the form of either a current and comprehensive medical report or practitioner's letter (Currency of the documentation will be based on the nature of the disability).
- An audiological report should be submitted.
- Documentation should include all criteria written above in General Guidelines.
- Diagnosis must be made by an audiologist or other practitioner qualified to make this diagnosis.

## Visual Impairments & Blindness

- Documentation should be in the form of either a current and comprehensive medical report or practitioner's letter (Currency of the documentation will be based on the nature of the disability).
- Documentation should include all criteria written above in General Guidelines.
- Diagnosis must be made by an ophthalmologist, optometrist, or other qualified practitioner.

## Speech Impairments

- Documentation should be in the form of a current and comprehensive speech and language evaluation, medical report or practitioner's letter (Currency of the documentation will be based on the nature of the disability).
- Documentation should include all criteria written above in General Guidelines.
- Diagnosis must be made by a speech pathologist or other practitioner qualified to make this diagnosis.