Verification Form

Bucks County Community College | Accessibility

Cognitive Impairments

Bucks County Community College's Accessibility Office (TAO) has established the Verification Form for Cognitive Impairments to obtain current information from a qualified practitioner (e.g., licensed medical practitioner, psychologist, psychiatrist, neuropsychologist) regarding a student's cognitive impairment symptoms and their impact on the student and his or her need for accommodations. This Verification Form should supplement information that is provided in other reports, including full neuropsychological or psychoeducational evaluations or secondary school documentation. Any documentation, including this Verification Form, must meet Bucks County Community College's TAO guidelines for Cognitive Impairments.

The person completing this form may not be a relative of the student or hold power of attorney over the student.

A summary of the guideline criteria for documenting cognitive impairments is as follows:

1. Persistent learning difficulties, memory challenges, inability to maintain attention, deficits of self-regulation, inability to process information verbally and visually, low IQ score, and academic performance below expectations as measured by objective and statistically sound assessments of aptitude and achievement
2. History of learning difficulties, memory challenges, inability to maintain attention, deficits of self-regulation, inability to process information verbally and visually, low IQ score, and academic performance
3. Functional limitations affecting an important life skill, including academic functioning
4. Exclusion of alternative diagnoses or attributing factors
5. Summary and recommendations

Section I: Student Information (Please type information or print legibly)

Student Name: ______________________
Last First Middle

Student ID: ______________ **Date of Birth:** ______________

Cell Phone: ______________ **Home Phone:** ______________

Bucks Email: ______________ **Home Email:** ______________

Permanent Street Address: ______________________

City: ______________ **State:** ________ **Zip:** ________

(If different from Permanent Street Address)

Local Street Address: ______________________

City: ______________ **State:** ________ **Zip:** ________

Section II: Provider Section (Please type information or print legibly)

A. Contact with the Student:

Date of initial contact with the student: ______________________

Date of last contact with the student: ______________________

B. Diagnosis Information:

1. Clinical History

Does the student have a history of a cognitive disorder? ☐ **YES** ☐ **NO**

Approximately at what age or grade did the student start to exhibit cognitive deficits or was assessed for a cognitive disorder? ______________

What date was the student diagnosed with cognitive impairment symptoms? ________ Month ________ Year

Please include any historical information relevant to the student's learning disorder and associated functioning (e.g., developmental, familial, medical, pharmacological, psychological, psychosocial).

2. Impact of Learning

a. Has the student demonstrated a persistent difficulty learning academic skills (for at least six months) despite targeted intervention(s) in the area(s) of academic difficulty related to a cognitive diagnosis? ☐ **YES** ☐ **NO**

b. Please check all areas of the student's documented academic skill difficulties that are substantially below expectations, related to a cognitive diagnosis, given the student's age:

☐	Word decoding and word reading fluency
☐	Reading comprehension
☐	Spelling
☐	Writing difficulties such as grammar, punctuation, organization, and clarity
☐	Number sense, fact and calculation
☐	Mathematical reasoning

c. Did you use objective and statistically sound assessments to evaluate the student's cognitive abilities and learning difficulties? ☐ **YES** ☐ **NO**

1) If yes, please provide information regarding the student's global intellectual functioning and current academic functioning as measured by aptitude and achievement tests respectively. This information can be attached to this Verification Form if contained within a neuropsychological or psychoeducational evaluative report (please include this report with the Verification Form).

Aptitude:
List the name of the comprehensive and current aptitude/cognitive instrument administered
List the standard scores per subtest; and (c) the percentiles per subtest

Achievement:
List the name of the comprehensive and current achievement battery administered
List the standard scores per academic area subtest
List the percentiles per academic area subtest

2) If no, how did you reach your conclusion about the learning disorder and necessary interventions and academic accommodations?

c. Does the student have an intelligence quotient (IQ) score? ☐ **YES** ☐ **NO**

1) Please provide the student's intelligence quotient (IQ) score.

3. Functional Impairment

a. Is there clear evidence that the student's learning difficulties are interfering with or reducing the quality of at least one of the following, including academic functioning?

Environmental Functioning:	
School functioning:	
Social functioning:	
Work functioning:	
Home functioning:	

b. Please check all that can be attributed to the student's academic and learning difficulties:

	Intellectual disability
	Visual or hearing impairment
	Psychological disorder (e.g., depression, anxiety, etc.)
	Neurological disorder
	Psycho-social difficulty
	Language differences (i.e., English as a second language)
	Lack of access to adequate instruction
	Inability to sustain attention
	Inability to inhibit one's own response to distractions
	Slow information processing speed
	Inability to flex or control thinking
	Inability to multitask
	Deficits in working memory
	Deficits in category formation
	Deficits in pattern recognition

4. ICD 10 Codes:

Please check the student's ICD 10 Code for Cognitive Impairment		
	F70	Mild intellectual disabilities
	F71	Moderate intellectual disabilities
	F72	Severe intellectual disabilities
	F73	Profound intellectual disabilities
	F79	Unspecified intellectual disabilities

5. World Health Organization Disability Assessment Schedule 2.0

a. Does the student have a WHODAS 2 Score? ☐ **YES** ☐ **NO**

b. If yes, please provide the score here: ____________________

6. Other Diagnosis and ICD 10 Codes?

a. Does the student have any other diagnosis? ☐ **YES** ☐ **NO**

b. If yes, please list the DSM-V Codes and the diagnosis in the space provided below:

ICD 10 Code:	Diagnosis

c. Does the student have a clinical history of alcohol abuse? ☐ **YES** ☐ **NO**

1) Please provide information regarding the student's history of alcohol abuse.

d. Does the student have a clinical history of drug abuse? ☐ **YES** ☐ **NO**

1) Please provide information regarding the student's history of drug abuse.

e. Does the student have a clinical history of verbal or physical aggression toward peers, family members or adults? ☐ **YES** ☐ **NO**

1) Please provide information regarding the student's history of verbal or physical aggression.

7. **Military Service**
   a. Has the student served in the military? ☐ **YES** ☐ **NO**
      1) What branch of the military did the student serve with?

	United States Air Force		United States Coast Guard		United States Navy
	United States Army		United States Marine Corp.		

   b. Is the diagnosis related to their service in the military? ☐ **YES** ☐ **NO**
      1) Please provide information regarding the student's history of cognitive needs related to their military service.

   c. Is the receiving treatment through United States Department of Veterans Affairs? ☐ **YES** ☐ **NO**
      1) At what location of the VA does the student receive services? ______________________

8. **World Health Organization Disability Assessment Schedule 2.0**
   a. Does the student have a WHODAS 2 Score? ☐ **YES** ☐ **NO**
   b. If yes, please provide the score here: ______________

C. Family History:

1. Does the student have a family history of physical health impairments? ☐ **YES** ☐ **NO**
2. If yes, please check all that apply:

	Mother		**Father**		**Siblings**
	Grandparents (Maternal)		**Grandparents (Paternal)**		**Aunts (Maternal)**
	Uncles (Maternal)		**Aunts (Paternal)**		**Uncles (Paternal)**
	Cousins (Maternal)		**Cousins (Paternal)**		

   a. If yes, please list the family history of any health disorders.

3. Does the student have a family history of any psychological or cognitive disorders? ☐ **YES** ☐ **NO**
4. If yes, please check all that apply:

	Mother		**Father**		**Siblings**
	Grandparents (Maternal)		**Grandparents (Paternal)**		**Aunts (Maternal)**
	Uncles (Maternal)		**Aunts (Paternal)**		**Uncles (Paternal)**
	Cousins (Maternal)		**Cousins (Paternal)**		

   a. If yes, please list the family history of any psychological disorders.

D. Educational History:

1. Did the student receive special education or intervention services at the K-12 level? ☐ **YES** ☐ **NO**

2. If yes, please check all that apply:

	Response to Intervention (RTI) Level 1		**504 Plan**
	Response to Intervention (RTI) Level 2		**Other:**
	Response to Intervention (RTI) Level 3		**Other:**
	Individualized Education Program (IEP)		**Other:**

3. Did the student have a modified curriculum at the K-12 level? ☐ **YES** ☐ **NO**

**** A modified curriculum means that the student had alternative or different exams and assignments than their peers.***

E. Assistive Technology and Durable Medical Equipment:

1. Does the student use assistive technology? ☐ **YES** ☐ **NO**

a. If yes, please list the assistive technology.

2. Does the student use durable medical equipment? ☐ **YES** ☐ **NO**

a. If yes, please list the durable medical equipment.

F. Office of Vocational Rehabilitation (OVR):

1. Is the student registered with the Office of Vocational Rehabilitation (OVR)? ☐ **YES** ☐ **NO**

a. At what location of OVR does the student receive services? ____________________

b. If yes, please list the services being provided by OVR.

2. Is the student receiving private wrap around services? ☐ **YES** ☐ **NO**

a. What is the name of the agency providing services? ____________________

b. If yes, please list the services being provided by the private agency.

G. Medication(s):

1. Is the student currently taking medication(s) for any symptoms related to the diagnosis? ☐ YES ☐ NO
2. Does the student have a history of noncompliance with medication? ☐ YES ☐ NO
   a. If yes, please list the behaviors or incidents of noncompliance with medication in the student's history.

3. If yes, please provide information below for each medication the student is currently prescribed:

Medication • Dosage • Frequency (e.g., Adderall 5 mg 1 x daily):	
Date Prescribed:	
Side effects that impact the student's functioning (e.g., concentration, sleep, thinking, eating, etc.):	

Medication • Dosage • Frequency	
Date Prescribed:	
Side effects that impact the student's functioning (e.g., concentration, sleep, thinking, eating, etc.):	

Medication • Dosage • Frequency	
Date Prescribed:	
Side effects that impact the student's functioning (e.g., concentration, sleep, thinking, eating, etc.):	

Medication • Dosage • Frequency	
Date Prescribed:	
Side effects that impact the student's functioning (e.g., concentration, sleep, thinking, eating, etc.):	

Medication • Dosage • Frequency	
Date Prescribed:	
Side effects that impact the student's functioning (e.g., concentration, sleep, thinking, eating, etc.):	

Medication • Dosage • Frequency	
Date Prescribed:	
Side effects that impact the student's functioning (e.g., concentration, sleep, thinking, eating, etc.):	

H. Functional Limitations and Recommended Accommodations:

1. Please list the student's current cognitive symptoms and then indicate what reasonable academic accommodations would mitigate the symptom listed.

2. **Sample:**

Symptom: (Example)
The student has poor working memory.
Recommended Reasonable Accommodation(s):
The ability to record lectures to review information presented multiple times.

Symptom:
Recommended Reasonable Accommodation(s):

Symptom:
Recommended Reasonable Accommodation(s):

Symptom:
Recommended Reasonable Accommodation(s):

Symptom:
Recommended Reasonable Accommodation(s):

Symptom:
Recommended Reasonable Accommodation(s):

Symptom:
Recommended Reasonable Accommodation(s):

Section III: Provider's Certifying Professional Information

(Please type information or print legibly)

Professionals conducting the assessment, rendering a diagnosis, and providing recommendations for reasonable accommodations must be qualified to do so (e.g., licensed medical practitioner, psychologist, psychiatrist, neuropsychologist). The provider signing this form must be the same person answering the above questions.

Provider Name: ______________________________

Last First Middle

Credentials: ______________________________

License Number: ____________________ **State of Licenser:** ____________________

Office Phone: ____________________ **Office Fax:** ____________________

Office Email: ____________________ **Office Website:** ____________________

Office Street Address: ______________________________

____

City: ____________________ **State:** __________ **Zip:** __________

Provider Signature: ______________________________ **Date:** __________

Section IV: Submitting This Form

It is the responsibility of the student to submit the form to the Accessibility Office (TAO) at Bucks County Community College where the student is enrolled. The student will submit the form to the Learning Specialist during their intake appointment when they register with TAO. Students will also be required to meet with a Learning Specialist if they would like to update their accommodations using the verification form or any other form of documentation.

Section V: How to Make an Intake Appointment

Students are encouraged to call or email the Accessibility Office (TAO) to schedule an appointment. Intake appointments are only done in person. There are certain times of year that appointment waiting times can be up to six weeks. The student identification number and Bucks email is required for students to obtain an intake appointment. Students are encouraged to contact TAO as soon as possible to ensure that their accommodations are approved and put into place as soon as possible. TAO's contact information is as follows:

Phone: (215) 968-8182

Email: accessibility@bucks.edu

Office: Bucks County Community College
275 Swamp Road
Rollins Center • Student Services Office • Room 001
Newtown, Pennsylvania 18940

Appointments can be scheduled for the Upper Bucks (Perkasie) and Lower Bucks (Bristol) campuses. TAO Learning Specialists are on each of the satellite campuses one day per week. The student should inform the TAO team member if they have a campus preference.

Information regarding the Accessibility Office (TAO), accommodations and assistive technology (AT) at Bucks County Community College can be found at https://www.bucks.edu/resources/campusresources/accessibility/. Please visit our website for the latest information and updates as they are made available. If you have any questions, please feel free to call us (215) 968-8182.