# Disability Verification Form for Mental Health Providers

Purpose: The student named below has indicated that s/he has a disability and will require reasonable accommodations to participate in a program or activity at Kean University. The information you provide will be one of the criteria used to evaluate the student’s eligibility for the requested accommodations or services. Please complete this form in its entirety. All information provided will be kept confidential in accordance with the Family Educational Rights and Privacy Act (FERPA).

## Student Information:

|  |  |
| --- | --- |
| Student’s First Name: |  |
| Student’s Last Name:  |  |

The remainder of this document must be completed by a certified/licensed Health Care Provider. Completion of the verification form is not adequate. Your medical provider MUST attach copies of evaluation and diagnostic evaluation reports for EACH area of disability.

Date of First Diagnosis: Click or tap to enter a date.

Date Student was first seen: Click or tap to enter a date.

Date Student was last seen: Click or tap to enter a date.

How long have you been treating the student?

|  |
| --- |
|  |
|  |

Frequency of Appointments:

 [ ]  Once a week

 [ ]  Twice a week

 [ ]  Once a month

 [ ]  Once every six months

 [ ]  Once a year

 [ ]  As-needed basis

|  |  |  |
| --- | --- | --- |
|  | [ ]  Other:  |  |

## **Psychological Condition Information:**

DSM-5 Diagnosis/ICD-10 Code(s)

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What is the expected duration of the condition?

[ ]  Short-term (less than 6 months)

[ ]  Episodic

[ ]  Long-term (6 months - 1 year)

[ ]  Chronic (longer than 1 year with frequent recurrence)

In addition to the DSM-5 criteria, how did you arrive at your diagnosis? Please check all relevant items.

[ ]  Structured or unstructured interviews with the person him/herself

[ ]  Interviews with other persons

[ ]  Behavioral observations

[ ]  Developmental history

[ ]  Educational history

[ ]  Medical history

[ ]  Neuropsychological testing

[ ]  Psychoeducational testing

[ ]  Standardized or unstandardized rating scales

|  |  |
| --- | --- |
| [ ]  Other:  |  |

If you selected Neuropsychological Testing, please provide the testing date: Click or tap to enter a date.

If you selected Psychoeducational Testing, please provide the testing date: Click or tap to enter a date.

## **Medication**

Is the student currently taking any medication? [ ]  Yes [ ]  No

If yes, please provide the requested information on each medication below:

 (e.g., Celebrex, 200 mg, 1x daily, 1/1/2020, Dr. John Doe)

**Medication 1, Dosage, & Frequency**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Medication Name** | **Dosage** | **Frequency** | **Date Prescribed** | **Prescribing Physician** |
|  |  |  |  |  |
| Side effects that impact the student’s functioning (e.g., concentration, sleep, thinking, eating, etc.): |
|  |
|  |

**Medication 2, Dosage, & Frequency**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Medication Name** | **Dosage** | **Frequency** | **Date Prescribed** | **Prescribing Physician** |
|  |  |  |  |  |
| Side effects that impact the student’s functioning (e.g., concentration, sleep, thinking, eating, etc.): |
|  |
|  |

**Medication 3, Dosage, & Frequency**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Medication Name** | **Dosage** | **Frequency** | **Date Prescribed** | **Prescribing Physician** |
|  |  |  |  |  |
| Side effects that impact the student’s functioning (e.g., concentration, sleep, thinking, eating, etc.): |
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|  |

**Medication 4, Dosage, & Frequency**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Medication Name** | **Dosage** | **Frequency** | **Date Prescribed** | **Prescribing Physician** |
|  |  |  |  |  |
| Side effects that impact the student’s functioning (e.g., concentration, sleep, thinking, eating, etc.): |
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|  |

**Additional Medication Comments:**

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## **Functional Limitations**

|  | **No impact** | **Moderate impact** | **Substantial impact** | **Don’t Know** |
| --- | --- | --- | --- | --- |
| Concentration  | [ ]  | [ ]  | [ ]  | [ ]  |
| Memory  | [ ]  | [ ]  | [ ]  | [ ]  |
| Sleep/Waking  | [ ]  | [ ]  | [ ]  | [ ]  |
| Eating  | [ ]  | [ ]  | [ ]  | [ ]  |
| Social interaction  | [ ]  | [ ]  | [ ]  | [ ]  |
| Self-Care  | [ ]  | [ ]  | [ ]  | [ ]  |
| Managing internal Distractions  | [ ]  | [ ]  | [ ]  | [ ]  |
| Managing external distractions  | [ ]  | [ ]  | [ ]  | [ ]  |
| Complex/Abstract thinking  | [ ]  | [ ]  | [ ]  | [ ]  |
| Attending class regularly and on time  | [ ]  | [ ]  | [ ]  | [ ]  |
| Making and keeping appointments  | [ ]  | [ ]  | [ ]  | [ ]  |
| Stress management  | [ ]  | [ ]  | [ ]  | [ ]  |
| Organization and prioritization of task(s)  | [ ]  | [ ]  | [ ]  | [ ]  |
| Stress management  | [ ]  | [ ]  | [ ]  | [ ]  |
| Other  | [ ]  | [ ]  | [ ]  | [ ]  |

If patient is taking medication, how does it impact the functional limitations listed above?

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What symptoms will accommodations target/mitigate? Are there any specific accommodations you might recommend that would help the student?

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Is there anything else you think we should know about the student’s psychological disability?

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**Health Care Provider Completing this form:**

Role of the individual completing this form (check all that apply).

|  |  |
| --- | --- |
| [ ]  Medical Doctor  | [ ]  Evaluator  |
| [ ]  Psychotherapist  | [ ]  Second Opinion Evaluator  |
| [ ]  Medication Supervisor  |  |
| [ ]  Other:  |  |

|  |  |
| --- | --- |
| Provider Full Name:  |  |
| License Number:  |  |
| Title/Profession:  |  |
| Street Address:  |  |
| City, State, Zip |  |
|  |  |
| Phone Number:  |  |
| Fax Number:  |  |
| E-mail Address: |  |

|  |  |
| --- | --- |
| Provider Signature: |  |

Today’s Date: Click or tap to enter a date.

**Please contact us with any questions at (908) 737-4910 or** **accessibilityservices@kean.edu**

**Please return this form to:** **accessibilityservices@kean.edu** **or**

**Office of Accessibility Services**

**Downs Hall Room 122**

**Kean University**

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