



OFFICE OF DISABILITY SUPPORT SERVICES APPLICATION FOR SUPPORT SERVICES

Name: _____ Student ID #: _____
First M.I. Last

Local Address: _____

City: _____ State: _____ Zip Code: _____

Cell Phone: (_____) - _____ - _____ Home Phone: (_____) - _____ - _____

E-mail _____

Are you a client of the Department of Rehabilitation? Yes | No

If yes, name of counselor: _____ Office: _____

Are you a client of the Veteran's Administration Rehabilitation? Yes | No

Disability is (check one): Permanent | Temporary

Please check the following items that directly apply to your situation:

Visual Impairment

- Partial Sight
- Blindness

Communication

- Deafness
- Hard of Hearing
- Speech Limitation

Functional Limitation

- Diabetes
- Epilepsy
- Other

Mobility

- Amputation
- Arthritis
- Cardiovascular
- Cerebral Palsy
- Hemophilia
- Multiple Sclerosis
- Post Polio
- Respiratory
- Spinal Cord Injury
- Other

Other:

- Emotional
- Autism Spectrum Disorder (ASD)
- Specific Learning Disability

Other Health:

Do you use any of the following?

- Manual Wheelchair
- Electric Wheelchair
- Crutches/Cane/Walker/Braces
- Respiratory Aids
- Hearing Aids
- Pacemaker
- Service Animal
- White Cane
- Other: _____

What are your sources of income?

- Family Supported
- Self-Supported
- Aid to Potentially Self-Supporting Blind
- AFDC
- Financial Aid (CSUSM)
- General Assistance
- SSI (Gold Check)
- SSDI (Green Check)
- Veteran's Benefits
- Other: _____

What reasonable accommodation(s) are you requesting (i.e. testing accommodations, large print material, sign language interpreters, priority registration)?

Please sign and date below:

Signature

Date