3080 Broadway
New York, NY 10027
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Verification of Disability Form for Mental Health Treatment Providers

Purpose: The student named below has indicated that they have a disability and will require reasonable accommodations to participate in a program or activity at JTS. The information you provide will be one of the criteria used to evaluate the student's eligibility for the requested accommodations or services. Please take the time to 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 Name:____

Date student was last seen: ____

Dates of treatment with current provider/facility: ____

Current Principal DSM-V Diagnosis with numerical code including specifier and subtype, if applicable:

____ Date of Diagnosis: _________________

Additional Diagnosis(es) in the order of focus of attention and treatment:

____ Date of Diagnosis: _________________

____ Date of Diagnosis: _________________

Associated Medical Condition(s), if applicable:

____ Date of Diagnosis: _________________

____ Date of Diagnosis: _________________

Current Status of each of the above condition(s) (e.g., Active, Progressing, Controlled, In Remission):

____
____
____
____

In addition to DSM-V criteria, how did you arrive at your diagnosis? Please check all that apply.

☐ Clinical interviews with student
☐ Interviews with other persons
☐ Behavioral observations
☐ Review of medical records
☐ Review of educational records
☐ Neuropsychological testing (include dates): ___________
☐ Standardized rating scale/assessment (please specify): ____
☐ Other (please specify): ____

In your current clinical assessment, please indicate the degree of the student's functional limitations on most days, keeping in mind the positive and negative effects of any treatment modalities and/or their personal circumstances:

☐ Mild ☐ Moderate ☐ Substantial ☐ Severe

Be as specific and detailed as possible to what exacerbates the student's condition(s) and any relevant psychosocial and contextual factors:

____

Please provide details regarding the following:

1. Student's treatment history: ____

2. Current treatment plan and expected duration of treatment (psychotherapy, medication, etc.):

____

Please provide the following information regarding any medications related to the condition(s) that the student is currently prescribed:

Medication	Dosage	Frequency	Positive Effects	Adverse effects

Please describe the way(s) that the student's condition presents for the student and/or how the student is individually impacted:

____

What are the student's current functional limitations with respect to the following areas? Please list below:

1) Time management and organization: ____

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____
____

2) Executive Functioning/ planning:____

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____
____
____

3) Self-care or social interactions: ____

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____

4) Sleeping: ____

____
____
____
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____

5) Cognitive processes such as concentration, memory, rapidity of information processing, fatigability: _________

____
____
____
____
____

6) Ability to attend or participate in class: ____

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____
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7) Learning: ____

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8) Other:____-
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Please provide specific recommendations regarding academic accommodations for this student, and a <u>rationale</u> as to why these accommodations/services are warranted, based upon the student's functional limitations (e.g. if a note taker is suggested, state the reasons for this request related to the student's symptoms).

Recommended accommodation: ____

Rationale: ____
____
____

Recommended accommodation: ____

Rationale: ____
____
____

Recommended accommodation: ____

Rationale: ____
____
____

Anticipated duration of need for accommodation: ____

Other pertinent information that would be helpful when determining accommodations for student:
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Please check the following that apply:

- ☐ I am the primary person involved in the student's treatment
- ☐ I am a part of the student's treatment team
- ☐ The student is my former patient, who is currently under the care of another provider
- ☐ I was the original person who diagnosed this student as having a disability

Name & Credentials of Treatment Provider: ____

License #:______________________________________State:_____________________________

Address: ____

Telephone: ____

Signature:____________________________________Date: ____________________________

☐ I hereby certify that the above information is true and correct and that the information provided is objective medical/ psychological information relative to this student's application for disability accommodations.

☐ I am not related to the student by blood or marriage