



Disabled Student Program & Services

Confidential Application for Services

DSPS provides educational services and access for eligible students with documented disabilities who intend to pursue coursework at West Los Angeles College. A variety of programs and services are available which allow eligible students with disabilities the opportunity to participate fully in all aspects of college programs and activities through appropriate and reasonable accommodations. Completion of this form constitutes an agreement to apply for DSPS services.

Section I. General Information

Academic Term

Academic Year

LACCD Student ID

Date of Birth

Gender

☐

Male

☐

Female

☐

Decline

Last Name

First Name

M.I.

Address

Unit/ Suit

City

State

Zip Code

Phone

Email

1. Primary Disability:

2. Secondary Disability:

The Los Angeles Community College District uses the information requested on this form for the purpose of determining a student's eligibility to receive authorized special services provided by the DSPS program. Personal information recorded on this form will be kept confidential in order to protect against unauthorized disclosure. Portions of this information may be shared with the Chancellor's Office of the California Community Colleges or other state or federal agencies; however, disclosure to these parties is made in strict accordance with applicable statutes regarding confidentiality, including the Family Educational Rights and Privacy Act (20 U.S.C. 1232 (g)). Pursuant to Section 7 of the Federal Privacy Act (Public law 93-579, 5 U.S.C. § 552a, note), providing your social security number is voluntary. The information on this form is being collected pursuant to California Educational Code Section 67310-67312, and 84850; and California Code of Regulations, Title 5, Section 56000 et seq.

3. Medical professional who can verify your disability :

Name

Address

City

State

Zip Code

Phone

4. What are our educational goals? (Check all that apply)

- | | |
|--|--|
| ☐ Prepare for a new career (new skills) | ☐ Bachelor's degree after AA degree |
| ☐ Advance current job/ career (update skills) | ☐ Bachelor's degree without AA degree |
| ☐ Vocational degree without transfer | ☐ Maintain certificate or license |
| ☐ AA degree without transfer | ☐ Improve basic skills |
| ☐ Vocational certificate without transfer | ☐ Undecided |

5. Check the age when your primary disability occurred:

- | | | |
|--|---|--|
| ☐ At birth | ☐ 6 to 18 years | ☐ 38 to 55 years |
| ☐ 5 years & under | ☐ 19 to 37 years | ☐ 56 years and over |

6. Are you a consumer with the Department of Rehabilitation?

☐ YES ☐ NO

Counselor Name

Counselor Phone

7. Are you receiving services from any other campus or community program related to a disability?

If so, please describe:

8. Have you ever received services for students with disabilities from any other college prior to attending West Los Angeles College?

☐ YES ☐ NO

9. Are you receiving Financial Aid?

☐ YES ☐ NO

I certify that the foregoing statements on my application for DSP&S are complete and accurate.

Student Signature: _____ Date: _____

Emergency Contact Information

Contact Name

Contact Relationship

Phone

Address

City

State

Zip Code

STATEMENT OF STUDENT RESPONSIBILITY

West Los Angeles College provides services and access for eligible students with documented disabilities who intend to pursue coursework at WLAC. Through appropriate and reasonable accommodations, students are provided the opportunity to participate fully in all aspects of WLAC programs.

Completion of this form is required before services are provided by DSPS.

Student Responsibilities:

1. I will provide DSPS with any information deemed necessary by DSPS to verify my disability (ies); i.e., medical doctor or rehabilitation counselor complete name, address and phone number.
2. I will meet with an academic counselor to complete a Student Educational Plan and I agree to meet annually to update my Student Educational Plan.
3. I will make measurable progress towards the goals established in the Student Educational Plan and meet academic standards established by the college.
4. I will utilize the DSPS services in a responsible manner according to the rights and responsibilities of DSPS.
5. I will comply with the Student Code of Conduct adopted by the Los Angeles Community College District.
6. I understand that I must attend a DSPS orientation before services are rendered.

I understand that I must fulfill the Program and Student Responsibilities in the DSPS Program. I have received a copy of the policy on suspension of DSPS services, and I understand the consequences of failing to comply with the rules for responsible use of DSPS services. I understand that I will be notified in writing before any action is taken to suspend services. By signing this application I affirm that I understand and agree with the DSPS Program and student responsibilities and I will abide by them.

Student Name: _____

Date: _____



Section II. Confidentiality

Student Release of Information

I, _____, grant permission for the DSPS department to release and exchange information consistent with the Federal Family Education Rights and Privacy Act of 1974, or other laws and regulations with the appropriate college staff through the Los Angeles Community College District. I am aware that all information will be used solely for the purpose of my educational planning and the implementation of services related to my disability. I am also aware that all information will be kept confidential. This release shall remain in effect until I notify DSPS in writing that it is no longer valid.

I authorize the release of information that may include one or more of the following records:

- Verification of Eligibility
- Functional Limitation (s)
- Academic Accommodation (s)
- Educational Records, Including Progress Reports, Assessment Scores.
- Other:

Student Signature: _____

Date: _____

***** OFFICE USE ONLY *****

Application processed by: _____ Check One: ____ Summer/Fall ____ Winter/Spring

Disability and services: (") Not Eligible (1) Primary, full services (3) Secondary, full service

____ A.B.I. ____ ADHD ____ Autism ____ Deaf/ Hard of Hearing ____ Intellect. Dis. ____ L. D. ____ Mental Health ____ Physical

____ Visual ____ Other: _____

DSPS Counselor/Specialist Signature: _____ Date: _____