Verification Form

Deaf and Hard of Hearing

Bucks County Community College | Accessibility

Bucks County Community College's Accessibility Office (TAO) has established the Verification Form for Deaf and Hard of Hearing to obtain current information from a qualified practitioner (e.g., audiologist, otolaryngologist (ear, nose, and throat physician), otologist) regarding a student's hearing impairment and its impact on the student and his or her need for accommodations. This Verification Form may supplement information that is provided in other reports, including audiograms, medical reports, or secondary school documentation. Any documentation, including this Verification Form, must meet Bucks County Community College's TAO guidelines for Deaf and Hard of Hearing conditions.

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 hearing impairments is as follows:

1. Evidence of current deaf and hard of hearing impairment
2. Functional impairment affecting an important life skill, including academic functioning
3. History of use of hearing devices or assistive technology related to deaf and hard of hearing impairment
4. 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 clinical history (i.e., prior to age 12) of deafness or a hearing impairment? ☐ **YES** ☐ **NO**

Approximately at what age did the student start to exhibit deafness or hearing impairment symptoms? _____

What date was the student diagnosed with deafness or hearing Impairment symptoms? _____ Month _____ Year

Adapted by permission from The Pennsylvania State University

2. Diagnosis, Condition and Symptoms

a. Please provide all ICD 10 Codes and diagnoses that apply to the student:

ICD 10 Code	Diagnosis

b. What is the severity of the impairment? ☐ **Mild** ☐ **Moderate** ☐ **Severe**

1) Please explain the severity checked above:

c. What is the expected duration of the impairment?

Short-term (<6 months):	☐	Long-term (>6 months-1 year):	☐
Episodic:	☐	Chronic (>1 year with frequent recurrence):	☐

1) Please explain the duration checked above:

d. Current Symptoms

1) What is the student's current loss of hearing as determined by an audiological assessment?

2) What is the date of the student's most current audiological assessment? _____ Month _____ Year

Please attach a copy of the most recent audiogram.

e. Is the hearing loss expected to remain stable or is it expected to decline? ☐ **Stable** ☐ **Decline**

1) If it is expected to decline, please describe the expected progression of the hearing loss.

f. Is there clear evidence that the symptoms associated with the hearing impairment are interfering with or reducing the quality of at least one of the following, including academic functioning?

School functioning:	
Social functioning:	
Work functioning:	
Language functioning:	

3. **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. Student's History:

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

2. **Assistive Technology (AT):**
   - **a.** Are hearing aids, FM systems, or other devices prescribed to assist the student's hearing? If so, what is the student's hearing threshold with the hearing aids, FM systems, or other hearing devices?
   - **b.** Does the student have a cochlear implant(s)? If so, when did the student get the cochlear implant(s) and in which ear(s) is the implant located (left or right)? What is the student's hearing threshold with the cochlear implant(s)?
   - **c.** If the student currently uses assistive or adaptive technologies related to his or her hearing impairment, please list specifics about the technology. What is the brand and model number for the student's hearing aids and/or cochlear implant? If the student needs an FM system or other hearing device in the classroom, what FM system or recommended hearing device would be compatible with the student's hearing aids or cochlear implant?
   - **d.** What is the student's preferred mode of accessing in-class lectures and materials (e.g., American Sign Language, Signed English, Real Time Captioning)?
   - **e.** Does the student have a clinical history of alcohol abuse? ☐ **YES** ☐ **NO**
     - **1)** Please provide information regarding the student's history of alcohol abuse.
   - **f.** Does the student have a clinical history of drug abuse? ☐ **YES** ☐ **NO**
     - **1)** Please provide information regarding the student's history of drug abuse.
   - **g.** 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.

3. 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 physical health 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? _____

E. 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 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**	☐	**Individualized Education Program (IEP)**
☐	**Response to Intervention (RTI) Level 3**	☐	**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.***

F. 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.):	

G. Functional Limitations and Recommended Accommodations:

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

2. **Sample:**

Symptom: (Example)
Due to hearing impairment, the student cannot hear videos during class. The student's impairment provides an inability to hear electronic voices.
Recommended Reasonable Accommodation(s):
Captioned Videos should be used in the classroom for the student to participate.

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 (i.e., audiologist, otolaryngologist [ear, nose, and throat physician], otologist). 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.