HIBBING COMMUNITY COLLEGE

Accessibility Services (218) 262-7363 Office
1515 East 25th Street (218) 263-2992 Fax
Hibbing, MN 55746

Application for Services

Thank you for your interest in services for students with disabilities provided by the Accessibility Services Office at Hibbing Community College. It is important that you return this application ***WITH*** supporting documentation well in advance of your enrollment if you are not yet a student. If you are a current student, you should complete the application and submit documentation as soon as you are aware of a disability related need for services. Such information will help the Accessiblity Services Office work with you to plan effective academic adjustments and auxiliary aids and services during your tenure as a student at HCC. Please refer to the ***Documentation Guidelines*** for specific documentation requirements for your disability.

*Please note that services can be delayed until a completed application is on file in the Accessibility Services Office and the disability has been properly verified according to the ***Documentation Guidelines***.

Name:_____Date:_____

Student ID/Star ID:_____ Social Security #:_____Birthdate:_____/_____/_____

Program:_____ HCC Advisor:_____

Address:_____ City, State, Zip: _____

Phone:_____ Cell:_____ Email:_____

I. General Nature of Disability/Disabilities

Please indicate by checking the appropriate response(s).

☐ 1. Hearing Impairment ☐ 2. Visual Impairment ☐ 3. Physical Impairment

☐ 4. Learning Disability ☐ 5. Psychological/Psychiatric Impairment ☐ 6. Speech Impairment

☐ 7. Other

To the best of your knowledge, please describe your disability. Include **diagnosis as well as cause and date of onset:** _____

_____

_____

_____

Please describe how your disability affects you in school **and** your daily life: _____

_____

Date of LAST evaluation by a doctor? _____

Name of Diagnosing Professional:_____

Are you taking any medication that may affect your performance or attendance at college? _____Yes _____No

Did you receive Special Education Services in high school? _____Yes _____No

Did you receive Disability Services at another college? _____Yes _____No

What services/accommodations did you receive in high school and/or college? _____

_____

Which services/accommodations were most helpful to you? _____

_____

II. Use of Assistive Technology and/or Document Conversion

☐ Screen Reader ☐ Speech Recognition ☐ Audio Tapes ☐ Alternative Format ☐ Assistive Hearing Devices

Please list program and describe use: _____

III. Special Circumstances

Would you need assistance with evacuation in the event of an emergency? _____Yes _____No

Is there special medical information or procedure that we should be aware of? _____Yes _____No

List/Explain:_____

****YOU MUST REQUEST ACCOMMODATIONS EVERY SEMESTER****

_____

Student Signature **Date**

_____

Disability Director Signature **Date**

Hibbing Community College

Accessibility Services

Authorization for Release of Information

LAST	FIRST	MI	Date of Birth	Social Security Number
			/ /	

I do hereby authorize Hibbing Community College to obtain/release to/exchange information with the following individual/agency for the purposes of determining eligibility and coordination of support services:

Name of School, Clinic, or Organization

Address City State Zip

I am requesting complete and coherent records and/or documentation of the following:

___ Educational Assessment including recommended accommodations

PLEASE NOTE: An IEP alone is not adequate to determine appropriate testing/evaluation or accommodations. Please include additional documentation if sending an IEP.

___ Specific Medical Diagnosis and recommended accommodations

___ Psycho-Educational Testing

___ Recommended Accommodations

Other _____

Please return documentation to:

Jennifer Boben
Disability Services
Hibbing Community College
1515 East 25th Street, Hibbing, MN 55746
Phone: (218) 262-7363 Fax: (218) 263-2992 jenniferboben@hibbing.edu

ACKNOWLEDGEMENT OF UNDERSTANDING:

- I understand that no disclosure of my records can be made without my written consent unless otherwise provided for in legal statutes and judicial decisions.
- I understand that this authorization may include the release of information relating to substance abuse, mental health issues, and other medical testing and diagnosis.
- I understand that I may revoke this consent at any time except to the extent that action has already been taken upon this release. Unless revoked, this release will be in effect for one year from the date below.
- I understand that information used or disclosed has the potential to be re-disclosed by the recipient and no longer protected by Federal privacy regulations.
- I understand by authorizing this use or disclosure of information, there will be no conditions placed on my health care or payment for my health care. I can refuse to sign this authorization and still be assured treatment, payment, enrollment, or eligibility benefits.
- I understand that I may inspect or copy the information used or disclosed.

_____

Student Signature Date

This information can be provided in alternate format upon request.