Documentation Guidelines

Welcome to Colby College Office of Access & Disability Services! The following document will outline the rationale, requirements and timelines for submitting documentation alongside requests for accommodations.

In college, individuals with disabilities are protected against discrimination under the Americans with Disabilities Act. To ensure access at Colby College, we use an individualized, collaborative process to determine appropriate and reasonable accommodations. This process requires documentation of the diagnoses as well as the specific ways in which the manifestation of the disability may impact an individual’s experience across the Colby campus. Documentation enables the staff of the Office of Access & Disability Services and in specific cases, staff from ancillary offices, to determine accommodations specific to an individual student’s needs.

Documentation is confidential.

Below you will find a description of the documentation required for various requests. This list is not exhaustive but does constitute the information needed to make informed decisions regarding accommodations. Colby College has final authority for determining accommodations.

In general, documentation should:

- Establish the presence of a disability through a clear diagnosis supported by reports including related test scores, evaluations and/or test results.

- Describe the likely impact of the disability on the individual’s participation in the learning process, housing, dining and all other aspects of campus. Discuss rationale for specific accommodations requested.

- Be on letterhead and include the name of the recognized authority. Documentation is typically provided by certified and/or licensed school psychologists, clinical psychologists, neuropsychologists, doctors, psychiatrists, occupational therapists, surgeons, and/or any other professionals with specific certification and experience in the identification of disabilities. The evaluator may not be related to the student.

- We ask that the information be no more than 3 years old.
Learning and/or Language Based Disabilities

Documentation of a Learning or Language Based Disability must include:

1. Diagnosis
   Documentation must include a specific diagnosis on professional letterhead that includes the professional title(s) of the evaluator, professional credentials, licensure information as well as date(s) of testing and is signed by the evaluator. The evaluator cannot be related to the student. Handwritten scores or summary sheets are not acceptable.

   Note that individual learning styles or academic weaknesses are not considered neurological disabilities for which accommodations can be granted.

2. Testing
   Testing must be current, generally within the past three years, in order that accommodations are appropriately suited to the current impact of the disability. Testing must be comprehensive. It is not acceptable to administer only one test for the purpose of diagnosis or establishing that substantial limitation exists. **Minimally, both an intellectual or cognitive and achievement test results with scores are required.**

   Preferred instrument for intellectual assessments:

   • Wechsler Adult Intelligence Scale-III (WAIS-III) or
   • Woodcock-Johnson Psycho-Educational Battery: Tests of Cognitive Ability

   Preferred instruments for achievement tests:

   • Woodcock-Johnson Psycho-Educational Battery-Revised: Tests of Achievement
   • Nelson-Denny Reading Test
   • Scholastic Abilities Test for Adults (SATA)
   • Woodcock Reading Mastery Tests-Revised
   • Wechsler Individual Achievement Test (WIAT)

   Preferred instruments for assessing areas of information processing, such as short and long-term memory, auditory and visual processing, and processing speed:

   • Detroit Tests of Learning-3 (DTLA)
   • WAIS-III
   • Woodcock-Johnson Psycho-Educational Battery: Test of Cognitive Ability
   • Bender Visual-Motor Gestalt
   • Wechsler Memory Scale

   This is not intended to be an exhaustive list or to restrict assessment in other pertinent and helpful areas such as vocational interests and aptitudes.
3. **Actual Test Scores**
Standard scores and percentiles must be provided for all normed measures. Grade equivalents are not acceptable unless standard scores and/or percentiles are also included. The evaluation must show evidence of a significant discrepancy in cognitive/achievement and in information processing that demonstrates a substantial limitation for which an accommodation is recommended as necessary in order for the student to access his/her educational program.

4. **Contextual Information**
As diagnoses alone not adequately capture a particular student’s needs, we also ask that you include any relevant documentation that helps us to best understand how the diagnosis might be experienced in the college setting. This documentation is meant to support and not take the place of the experiences of the student.

Examples include IEPs, 504 plans, clinical or teacher observations that describe the impact of the diagnosis, transcripts, report cards, teacher comments, tutoring evaluations, past psychoeducational testing, and/or other third-party interviews.
If no history exists, then an explanation should be included regarding why accommodations were not used, and why they are now needed.

5. **Recommended Accommodations**
Suggestions for appropriate accommodations or assistive technology, aides or services should be included. Typically, either the evaluator or a school personnel member knowledgeable of the student’s academic experiences will write a letter giving a brief rationale substantiating the need for accommodation based on the impact of the disability. However, it is important to note that services provided in high school will not necessarily be appropriate in a university setting and are determined as they relate to a different legal threshold. Accommodations that would fundamentally alter the essential nature of a course or program will not be implemented, nor any measures that will give the student an unfair advantage over other students.

**ADD/ADHD**

To ensure the provision of reasonable and appropriate accommodations for students with ADHD/ADD, the following information should be provided in the documentation. *Note that for students receiving their initial diagnosis in college, intellectual or cognitive and achievement test results with scores are also required. A doctor's letter alone is not sufficient to receive accommodations.*

1. **Diagnosis**
Documentation must provide a specific diagnosis of ADHD based on the DSM-V diagnostic criteria and be stated explicitly. This should be provided on letterhead that includes the professional title(s) of the evaluator, professional credentials, licensure information as well as date(s) of testing and is signed by the evaluator. The evaluator cannot be related to the student.

2. **Testing/Evaluations**
The provision of reasonable accommodations and services is based upon
assessment of the current impact of the disability on academic performance. While a diagnostic evaluation is best when completed within the last three years, older results may be acceptable under certain conditions on a case-by-case basis.

Due to the nature of ADD/ADHD diagnoses, we ask that the clinician give supporting documentation detailing the following:

- Developmental and Medical History - At what age did the student begin experiencing symptomology, to what degree and what types of strategies etc. were used to support the student.

- Manifestation of Symptoms – Discuss how the student has experienced their diagnosis throughout childhood, adolescence and currently at school, home and in their social lives. Describe typical patterns of inattentiveness, impulsivity and/or hyperactivity as they relate to environmental and social factors, stressors etc.

- Treatment/ Responses – Discuss strategies, therapies, medication etc, used to support the student in managing their symptoms. What types of strategies, medication, therapies etc. has the student used and how have they been effective, or not.

3. Contextual Information

As diagnoses alone not adequately capture a particular student’s needs, we also ask that you include any relevant documentation that helps us to best understand how the diagnosis might be experienced in the college setting. This documentation is meant to support and not take the place of the experiences of the student.

Examples include IEPs, 504 plans, clinical or teacher observations that describe the impact of the diagnosis, transcripts, report cards, teacher comments, tutoring evaluations, past psychoeducational testing, and/or other third- party interviews. If no history exists, then an explanation should be included regarding why accommodations were not used, and why they are now needed.

4. Recommended Accommodations

Discuss how the student’s current functions might be impacted by their diagnosis. Consider the college setting which includes housing, labs, testing, mobility and social events. What accommodations would benefit the student most and why? Describe past and current treatments, medications, and assistive technologies used and how they impacted the student.

Mental Health/Psychological Disabilities
To ensure the provision of reasonable and appropriate accommodations for students with Mental Health/Psychological Disabilities, the following information should be provided in the documentation:

1. Diagnosis
Documentation must provide specific diagnosis(es) utilizing diagnostic categorization or classification of the ICD or DSM V. Diagnoses should be stated explicitly and comprehensively particularly in respect to presenting problems.

This should be provided on letterhead that includes the professional title(s) of the evaluator, professional credentials, licensure information as well as date(s) of testing and is signed by the evaluator. The evaluator cannot be related to the student.

2. Testing/ Evaluations
Discuss tests and methods used to determine the diagnosis and the date the examination/assessment/evaluation was performed for the presenting diagnosis, or if following the student for an extended time, date of onset and date of an evaluation of the condition that is recent enough to demonstrate the student’s current level of functioning.

PLEASE do not send copies of the student’s medical records.

3. Contextual Information
As diagnoses alone not adequately capture a particular student’s needs, we also ask that you include any relevant documentation that helps us to best understand how the diagnosis might be experienced in the college setting. This documentation is meant to support and not take the place of the experiences of the student.

Examples include IEPs, 504 plans, clinical or teacher observations that describe the impact of the diagnosis, transcripts, report cards, teacher comments, tutoring evaluations, past psychoeducational testing, and/or other third- party interviews.
If no history exists, then an explanation should be included regarding why accommodations were not used, and why they are now needed.

4. Recommended Accommodations
Discuss how the student’s current functions might be impacted by their diagnosis. Consider the college setting which includes housing, labs, testing, mobility and social events. What accommodations do you feel would benefit the student most and why? Describe past and current treatments, medications, and assistive technologies used and how they impacted the student.

Physical Disabilities

To ensure the provision of reasonable and appropriate accommodations for students with Physical Disabilities, the following information should be provided in the documentation:
1. **Diagnosis**
Documentation must provide specific diagnosis(es). Diagnoses should be stated explicitly and comprehensively particularly in respect to presenting problems.

This should be provided on letterhead that includes the professional title(s) of the evaluator, professional credentials, licensure information and is signed by the evaluator. The evaluator cannot be related to the student.

2. **Testing/ Evaluations**
Describe the particular limitations related to the physical disability and if applicable estimate timelines for healing, recovery or change in function due to treatments, surgeries etc.

**PLEASE do not send copies of the student’s medical records.**

3. **Contextual Information**

As diagnoses alone not adequately capture a particular student’s needs, we also ask that you include any relevant documentation that helps us to best understand how the diagnosis might be experienced in the college setting. This documentation is meant to support and not take the place of the experiences of the student.

Examples include IEPs, 504 plans, clinical or teacher observations that describe the impact of the diagnosis, transcripts, report cards, teacher comments, tutoring evaluations, past psychoeducational testing, and/or other third-party interviews.

If no history exists, then an explanation should be included regarding why accommodations were not used, and why they are now needed.

4. **Recommended Accommodations**

Discuss how the student’s current functions might be impacted by their diagnosis. Consider the college setting which includes housing, labs, testing, mobility and social events. What accommodations would benefit the student most and why? Describe past and current treatments, medications, and assistive technologies used and how they impacted the student.

**Chronic/Severe Illness**

To ensure the provision of reasonable and appropriate accommodations for students with Chronic or Severe Illness, the following information should be provided in the documentation:

1. **Diagnosis**
Documentation must provide specific diagnosis(es) utilizing established criterion. Diagnoses should be stated explicitly and comprehensively including details as to the types of experiences related to the chronic illness, i.e. flare ups, duration of flare ups as well as types of situations that may induce a flare up. The more detailed the discussion of the various symptoms, the better.
This should be provided on letterhead that includes the professional title(s) of the evaluator, professional credentials, licensure information as well as date(s) of testing and is signed by the evaluator. The evaluator cannot be related to the student.

2. Testing/ Evaluations
Discuss tests and methods used to determine the diagnosis and the date the examination/assessment/evaluation was performed for the presenting diagnosis, or if following the student for an extended time, date of onset and date of an evaluation of the condition that is recent enough to demonstrate the student’s current level of functioning.

PLEASE do not send copies of the student’s medical records.

3. Contextual Information
As diagnoses alone not adequately capture a particular student’s needs, we also ask that you include any relevant documentation that helps us to best understand how the diagnosis might be experienced in the college setting. This documentation is meant to support and not take the place of the experiences of the student.

Examples include IEPs, 504 plans, clinical or teacher observations that describe the impact of the diagnosis, transcripts, report cards, teacher comments, tutoring evaluations, past psychoeducational testing, and/or other third-party interviews. If no history exists, then an explanation should be included regarding why accommodations were not used, and why they are now needed.

4. Recommended Accommodations
Discuss how the student’s current functions might be impacted by their diagnosis. Consider the college setting which includes housing, labs, testing, mobility and social events. What accommodations would benefit the student most and why? Describe past and current treatments, medications, and assistive technologies used and how they impacted the student.

Medical Conditions
To ensure the provision of reasonable and appropriate accommodations for students with specific medical conditions the following information should be provided in the documentation:

1. Diagnosis
Documentation must provide specific diagnosis(es) utilizing established criterion. Diagnoses should be stated explicitly and comprehensively including details as to the types of experiences related to the chronic illness, i.e. flare ups, duration of flare ups as well as types of situations that may induce a flare up. The more detailed the discussion of the various symptoms, the better.
This should be provided on letterhead that includes the professional title(s) of the evaluator, professional credentials, licensure information as well as date(s) of testing and is signed by the evaluator. The evaluator cannot be related to the student.

2. Testing/ Evaluations
Discuss tests and methods used to determine the diagnosis and the date the examination/assessment/evaluation was performed for the presenting diagnosis, or if following the student for an extended time, date of onset and date of an evaluation of the condition that is recent enough to demonstrate the student’s current level of functioning.

PLEASE do not send copies of the student’s medical records.

3. Contextual Information

As diagnoses alone not adequately capture a particular student’s needs, we also ask that you include any relevant documentation that helps us to best understand how the diagnosis might be experienced in the college setting. This documentation is meant to support and not take the place of the experiences of the student.

Examples include IEPs, 504 plans, clinical or teacher observations that describe the impact of the diagnosis, transcripts, report cards, teacher comments, tutoring evaluations, past psychoeducational testing, and/or other third-party interviews. If no history exists, then an explanation should be included regarding why accommodations were not used, and why they are now needed.

4. Recommended Accommodations

Discuss how the student’s current functions might be impacted by their diagnosis. Consider the college setting which includes housing, labs, testing, mobility and social events. What accommodations would benefit the student most and why? Describe past and current treatments, medications, and assistive technologies used and how they impacted the student.