1515 Monrovia Ave., Newport Beach, CA 92663 • (714) 241-6214 • Fax: (714) 431-3602• TDD (714) 751-2072

SPECIAL PROGRAMS AND SERVICES FOR THE DISABLED

Application

The following application is to be completed by the potential student unless physically unable (e.g., due to visual impairment).

If completed by someone other than the applicant, who is completing the application?

Name ______________________________

Relationship to Prospective Student ______________________________

Reason ______________________________

Conservatorship: Yes No

Applicant's Name ______________________ Social Security # ______________________

Address ______________________ City ______________ Zip __________

Phone Number ( ) ______________________ Date of Birth ______________ Age __________

Cell ( ) ______________________ E-mail Address ______________________

Nature of Disability:

- ☐ Acquired Brain Injury
- ☐ Learning Disability
- ☐ Developmentally Delayed Learner
- ☐ Psychological Disability
- ☐ Other Disability
- ☐ Hearing Impairment
- ☐ Mobility Impaired
- ☐ Visually Impaired
- ☐ Speech, Language Impaired

Date of onset of disability ______________________ Age at time of Onset ______

If disability resulted from trauma or illness, please briefly describe conditions surrounding trauma/illness (e.g. head-on auto collision resulting in fractured skull):

____

____

If in coma, how long did it last? ______________________________

Are you presently a client of the Department of Rehab? ☐ Yes ☐ No

If yes, give address please: ______________________________

______________________________ ☐

Counselor: ______________________ Phone ( ) ______________

Are you currently receiving benefits from: ☐ AFDC/TANF ☐ General Assistance ☐ SSI/SSP

LONG-TERM GOAL:

- ☐ Transfer
- ☐ AS/AA Degree
- ☐ Certificate
- ☐ Job Skills
- ☐ Personal/Social Development
- ☐ Basic Skills
- ☐ Other

Family support and involvement are often important to the student's success. May we have your permission to include your parent(s), guardian, spouse, and/or significant other in meetings/discussions regarding your individual program and to share your records with that individual? ☐ Yes ☐ No

If yes, please identify the individual you wish to have included:

Name____ Relationship to you ______________________

Address ______________________________________ City __________________ Zip ____________

Home Phone ( ) ____________________________ Business Phone ( ) __________________

I HEREBY DECLARE THE STATEMENTS AND ANSWERS IN THIS APPLICATION ARE TRUE AND COMPLETE TO THE BEST OF MY KNOWLEDGE. I AUTHORIZE INVESTIGATION OF ALL STATEMENTS CONTAINED IN THIS APPLICATION, AND I HEREBY RELEASE FROM ALL LIABILITY ANY PERSON(S) OR ORGANIZATION(S) FURNISHING SUCH INFORMATION. I UNDERSTAND THAT FALSIFICATION, MISREPRESENTATION, OR OMISSION OF THE FACTS IS CAUSE FOR REJECTION OF THE APPLICATION, REMOVAL OF MY NAME FROM CONSIDERATION, OR DISMISSAL FROM SPECIAL PROGRAMS AND SERVICES FOR THE DISABLED.

______________________________ ____

Date **Applicant's signature**

______________________________ ____

Date **Signature of parent or guardian**
(If applicant is under 18 years of age or legal ward)