Disability Disclosure Form – Hearing Loss

Date: __________________________

Dear (Clinician Name) ____________________________________________________:

I am requesting services from the Disability Resource Center (DRC) at Northeastern University. In order to receive services, the DRC requires documentation of my disability. Services at the DRC are solely based on diagnostic documentation. Once this information is in place, it will be used to develop a service plan for me.

☐ I hereby authorize you to complete the enclosed Disclosure Form and release it to the DRC.

☐ I authorize you to attach a copy of my current audiological report, as requested.

☐ I also authorize you to speak with my DRC Specialist in consultation to provide future services.

Please submit the completed form to:

Ms. Debbi Auerbach, Service Coordinator

By mail:
Northeastern University
Disability Resource Center
20 Dodge Hall
Boston, MA 02115

By confidential fax: 617-373-7800

You may contact Ms. Auerbach with any questions (phone: 617-373-2675 / TTY: 617-373-2730 or email: d.auerbach@neu.edu).

Thank you for your timely assistance with this matter.

Sincerely,

__________________________________________  __________________________
Student Signature                          Date

__________________________________________  __________________________
Print Name                                Medical Record ID#

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This form must be completed by the licensed clinician or health care provider who is treating this patient for the diagnosis identified in this document. Please attach the most recent evaluation(s) and a copy of a current audiology report.

Patient’s/Client’s Name: ____________________________________________________________

Clinician’s Name: _____________________________________________________________________

Clinician’s State Licensure/ Certification #: ____________________________________________

Area of Specialty: __________________________________________ Clinician’s phone #: ___________________________

The person named on this form is requesting services from the Disability Resource Center. The DRC offers services to students who are considered disabled under the mandates of the Americans with Disabilities Act of 1990 (ADA). Under the ADA definition, a person with a disability is one with a physical, mental, emotional or chronic health impairment that substantially limits one or more major life activity such as caring for oneself, performing manual tasks, seeing, hearing, eating, sleeping, walking, standing, lifting, bending, speaking, breathing, learning, reading, concentrating, thinking, communicating, and working. Major life activities also include bodily functions relating to the immune system, normal cell growth, digestive, bowel, bladder, neurological, brain, respiratory, circulatory, endocrine, and reproduction (this is not an exhaustive list).

I verify that the person named in this document has a substantially limiting disorder that meets the aforementioned ADA disability criteria: Yes ☐ No ☐

If yes, please thoroughly complete this form to document the substantial limitations that are linked to this disability.

• Diagnosis/Description of Disability: __________________________________________________________

• Please provide full DSM or ICD-9 code: __________________________________________________________________________

• Initial Date of Diagnosis: ________________ Date of last clinical contact: ________________

• Expected duration of disability noted above is:
  ☐ Permanent ☐ Short term (60-90 days)
  ☐ Chronic ☐ Temporary (1-60 days)
  ☐ Long term (3-12 months)

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The level of hearing loss is:  □ Mild   □ Moderate   □ Severe   □ Profound

Assessment Instruments and Results (Please describe the procedures, assessment tools, etc. used to establish the diagnosis):

Please describe the functional impact of the disability/symptoms on this individual’s:
□ Daily life (include any limitations related to personal care, social interactions, manual tasks, etc.)

□ Academic environment (note: please consider situations in and out of the classroom)
Please comment on the following items as applicable:

- **If DeafBlind, rate Mobility and Orientation (travel skills):** Novice Intermediate Advanced
  
  (Please include current vision evaluation report; see Disclosure Form for Blind/Vision Impairment)

- **Communication method (indicate all that are used):**
  
  □ American Sign Language
  
  □ Signed English (PSE)
  
  □ Other Signed Language (e.g. Spanish)
  
  □ Cued Speech
  
  □ Oral: English. Other Language: __________
  
  □ Tactile Sign Language
  
  □ Close Vision Signing
  
  □ Other: ________________________________

- **This person uses any or all of the following (indicate specific device or service):**
  
  □ Hearing Aids
    
    ___Bilateral
    
    ___Unilateral
    
    (type/model: ________________________)
  
  □ Cochlear Implant. Type: __________
    
    Month/Year of surgery: __________
    
    Month/Year of most recent map: __________
  
  □ Service Animal (Hearing Dog)
  
  □ Assistive Listening Device
    
    (please specify: ________________________)
  
  □ Other Technology/Aids
    
    (please specify: ________________________)
  
  □ Note-taking
  
  □ Oral Transliteration
  
  □ Preferential Seating
  
  □ Sign Language Interpreting/Transliterating
  
  □ Other: ____________________________

- **Suggested accommodation(s) for the academic setting:**
  
  □ Alternate Text Formats (DeafBlind)
  
  □ Assistive Listening Device
  
  □ CART
  
  □ Captioned Media
  
  □ Housing (circle any that apply)
    
    o Signaling: Visual Vibration
    
    o Service Animal Relief Area
    
    o Other: __________________________
  
  □ Note-taking
  
  □ Oral Transliteration
  
  □ Preferential Seating
  
  □ Sign Language Interpreting/Transliterating
  
  □ Other: __________________________

- **Additional information:**

  NOTE: Please attach a current Audiology Report to this Disclosure Form

  __________________________________________  ___________________________
  Clinician/Professional Signature                  Date

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