

How to submit your DSS intake form

Filling out the intake form on mobile devices

1. Search for 'Adobe Reader' in your marketplace store and install it
2. Open the email with the intake form attached
3. Press and hold the attachment for 5 seconds until the menu pops up
4. Select 'Adobe Reader' as the opening application
5. Fill out the paperwork and sign it
6. Select 'Share' from the menu and select your preferred email client
7. Email to Marcee.Keller@erau.edu with the subject 'Intake Form: (your Student ID Number) OR (Last name, first name)'

Filling out the intake form on computers

1. Ensure 'Adobe Reader' is present on the computer
2. Download the intake form attachment from your email
3. Fill out the form and sign it
4. Save the form
5. Attach the form to an email to Marcee.Keller@erau.edu with the subject 'Intake Form: (your Student ID Number) OR (Last name, first name)'

Filling out the intake form by hand (electronic return)

1. Print the form
2. Fill out and sign the form
3. Scan the form into a computer. If you do not have a scanner:
 - a. Download 'CamScanner' onto your phone. It does require a free account to use.
 - b. Click the camera to start a new document
 - c. Take a photo of page 1 and press the check mark
 - d. Adjust the edges so the whole form is in the box and press the check
 - e. If it looks legible, press the check mark again
 - f. Click the camera labeled 'Add' at the bottom of the screen to add the next page
 - g. When all pages are present, press 'Share' and select your preferred email client
 - h. Email to Marcee.Keller@erau.edu with the subject 'Intake Form: (your Student ID Number) OR (Last name, first name)'

Filling out the intake form by hand (manual return)

1. Print the form
2. Fill out and sign the form
3. Return to DSS (Bldg. 49) between the hours of 8:30 am and 4:00 pm Monday - Friday

Disability Services Intake Form

For Internal Use Only :

Date of contact: ____/____/20____ Interviewer: _____
Initial term at ERAU: _____ Referred by: _____

Personal Information

First Name: _____ Last Name: _____
Date of Birth: ____/____/____ Student ID: _____
Home Address: _____
City: _____ State: _____ Zip: _____
Address while at ERAU: _____ ERAU Box #: _____
City: _____ State: _____ Zip: _____
Home phone: ____-____-____ Cell phone: ____-____-____
Email address: _____
Emergency contact name: _____ Contact's number: ____-____-____
Are you a veteran? Yes: No:
Primary disability: _____
Secondary disability: _____

Educational Background

High schools attended:
1. _____
2. _____
Colleges attended:
1. _____
2. _____
Area of Study (major/minor) at ERAU:

Career goals (i.e. job title, ideal employer and work environment):

Will you be working during the school year: Yes: No:
If yes, how many hours per week? _____

Disability and Health History

For the following questions, limit answers to 50 words or less. Attach any additional information in document form.

Dates of initial disability diagnosis and/or limiting health incident(s) or issue(s):

Do you have any health conditions (such as seizures, blackouts, migraines, asthma, diabetes, etc.)?

Present Health

State your present health: **Poor:** **Fair:** **Good:** **Excellent:**

If fair or poor, please explain:

Have you been hospitalized in the last 5 years? **Yes:** **No:**

For what reasons: _____

Please list current medications

Medication:

Condition for use of medication:

- | | | |
|----|-------|-------|
| 1. | _____ | _____ |
| 2. | _____ | _____ |
| 3. | _____ | _____ |
| 4. | _____ | _____ |
| 5. | _____ | _____ |

How does your disability affect the following **ACADEMIC** activities?

ACTIVITY	Does not affect me	Affects me a little	Affects me a lot
Reading speed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Reading comprehension	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Spelling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Writing papers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Math	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Understanding vocabulary	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Memory	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Attention/concentration	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Study skills	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Time management	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Comprehending ideas	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Organization	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Test taking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Understanding lectures	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Taking notes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

How does your disability affect the following **LIFE** activities?

ACTIVITY	Does not affect me	Affects me a little	Affects me a lot
Caring for yourself	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eating	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Talking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sitting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hearing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Seeing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Breathing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Walking/Standing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lifting/Carrying	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Performing manual tasks	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Self-control	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Interacting with others	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Please describe, in your own words, what steps you are taking to manage your disability?

Accommodations

Please list all disability related services you received or used during high school that you found helpful (e.g., extended test time, resource room, special classes, etc.)

Services:

Why helpful:

- | | | |
|----|-------|-------|
| 1. | _____ | _____ |
| 2. | _____ | _____ |
| 3. | _____ | _____ |
| 4. | _____ | _____ |
| 5. | _____ | _____ |

Information concerning your disability is treated confidentially and is only shared with staff at ERAU on a “**need-to-know basis**”. By checking “Yes” below and signing this form, you give ERAU permission to share information concerning disclosed disability and request for reasonable accommodation(s) with campus professionals (professors, advisors, counselors, safety, and health services).

Please initial:

_____ **YES, I request assistance arranging my accommodation(s) and authorize sharing information on a need-to-know basis as stated above.**