

Psychological – Documentation Guidelines

OVERVIEW

Students who are seeking disability services through the Office of Specialized Services (OSS) at Ramapo College on the basis of a psychological diagnose are required to submit documentation to verify eligibility under Section 504 of the Rehabilitation Act of 1973 and the Americans with Disabilities Act of 1990 as amended. It is important to understand that a diagnosis in itself does not substantiate a disability. In others words, information sufficient to render a diagnosis might not be adequate to determine that an individual is substantially impaired in a major life activity. Current and comprehensive documentation must be provided in order for a student to be eligible for support services and consider protected under the law.

Secondary schools and post-secondary institutions are governed under different laws with regard to providing services to students with disabilities. A prior history of accommodation does not in and of itself warrant the provision of a similar accommodation at the post-secondary level. A student's high school Individualized Education Program (IEP) or a 504 Plan is seldom sufficient documentation to establish the rationale for academic adjustments, auxiliary aids and/or services in the post-secondary setting. A possible exception would be an IEP, or 504 Plan that meets all of the requirements defined by these guidelines.

The following guidelines are provided in the interest of assuring that documentation is appropriate to verify eligibility and support requests for reasonable accommodations, academic adjustments, and/or auxiliary aids at the postsecondary level. A documentation form has been developed as an alternative to a traditional diagnostic report. The form can be found at the OSS website ([OSS Website Documentation Guidelines](#)).

DOCUMENTATION GUIDELINES

Qualifications of the Evaluator

Professionals conducting assessments, rendering psychological diagnoses and making recommendations for appropriate accommodations must be qualified to do so. Professionals are considered qualified by having comprehensive training and direct experience in the differential diagnosis of such as a psychologist, psychiatrist, or certified social worker. It is not appropriate for professionals to evaluate members of their family or others with whom they have personal or business relationships.

Clerical Requirements

All diagnostic reports must include the names, titles, and professional credentials of the evaluators and include the signature of the professionals and the date(s) of testing/assessments. The report must be typed and submitted on professional letterhead. Specific reporting format is left to the professional, but the required components must be clearly presented and easily discernable. Handwritten diagnostic reports are not acceptable.

Background Information

Information regarding the student should be presented in the diagnostic report that provides relevant background. The information should be from variety of sources and should include such things as: history of presenting symptoms, developmental history, family history, medical and medication history, psychosocial history, academic history of elementary, secondary, and post-secondary education, and summary of prior psycho-educational evaluations.

Current Assessment

The diagnostic report must be based on assessment information that is recent in order to accurately describe a student's current functional limitations and need for academic adjustments, auxiliary aids and/or services. Assessment information that is less than two years old is typically considered current. Information that is more than a year old may be considered out of date depending on such factors as the student's current age, student's age at time of assessment and the nature of the diagnosis.

Diagnosis Explanation

The diagnostic report should include a review and discussion of the DSM-V criteria used in the diagnosis. This review should include: current and past symptoms, duration (chronic, episodic, or short term) of the condition and severity (mild, moderate, or severe) of the symptoms.

Assessment Process

It is expected that a description of the particular criteria and/or diagnostic tests used in the assessment will be explained. Student's self-report alone is not consider sufficient evidence to support disability eligibility.

Limitations

A description of the student's current functional limitations are expected within the report. In addition, it is important to provide an explanation of any significant limitations in functioning directly related to a prescribed medication.

Treatment

It is helpful to include the treatment, medications, assistive devices/services that are currently being used by the student.

Accommodations

It is helpful if the assessment reports include specific recommendations for accommodations as well as an explanation as to why each accommodation is recommended based on the evaluation. In addition, it is helpful to provide a description of any accommodation and/or auxiliary aid that has been used at the secondary or postsecondary level. Information about the specific conditions under which the accommodation was used (e.g., standardized testing, final exams) and whether or not it benefited the student is useful. If no accommodations have been previously provided, it would be productive to explain why none has been used and the rationale for why the student is currently in need of accommodation(s).

Documentation Retention

All submitted materials will be held in OSS as educational records under the Family Educational Rights and Privacy Act (FERPA). Students have a right to review their educational record. However, students are encouraged to retain their own copies of disability documentation for future use as the college is not obligated to produce copies for students. Under current New Jersey record retention requirements, disability documentation is mandated to be held for only two years after a student has stopped attending the college.