

Psychological/Psychiatric Disability – Documentation Guidelines

Documentation submitted to the Center for Disability & Access must indicate that a specific condition exists and that the identified condition substantially limits one or more major life activity (e.g. walking, seeing, speaking, hearing, breathing, learning, etc.). A diagnosis of a condition does not automatically qualify a student for accommodations under the Americans with Disabilities Act. **The documentation for a psychological condition must demonstrate that the condition rises to the level of a disability.**

The documentation should include the following specific components:

- **Format** – typed/printed on official letterhead, dated, and signed from a licensed and qualified professional (e.g. psychologists, neuropsychologists, psychiatrists, clinical social workers, licensed counselors, psychiatric nurse practitioners, and other relevantly trained healthcare professionals qualified to make such diagnoses).
- **Diagnosis** – the specific DSM-V coded diagnosis is preferred.
- **History and Prognosis** – a summary of the history and prognosis of the condition.
- **Treatment** – relevant information regarding the current treatment of the condition.
- **Current Impact** – a summary of current symptoms, severity (frequency and duration), and impact of the condition.
- **Limitations** – a statement regarding the functional limitations of the condition on learning and major life activities.
- **Medications** – a summary of the medications prescribed with their current effects. (A positive response to medication does not necessarily confirm a diagnosis or support/negate the need for accommodations.)
- **Assessment Procedures** – a summary of the assessment procedures use to make the diagnosis and the results of the evaluation, including standardized and percentile scores (if applicable).
- **Accommodations** – a summary of recommended and suggested accommodations. (Requested accommodations must be tied to the functional limitations of the individual relevant to the academic setting. A history of accommodations without demonstrating current need does not necessarily warrant accommodations. If there is no history of accommodations the documentation must include a detailed explanation of why accommodations were not needed in the past and why they are now requested.)

Please also note the following statements regarding documentation:

- **Documentation must be recent.** If the diagnostic report is more than **six months** old, the student must submit a letter from a qualified professional that provides an update of the diagnosis, a description of the student's current level of functioning during the preceding six months, and a rationale for the requested accommodations.
- The evaluator must also investigate and rule out the possibility of other potential diagnoses involving neurological and/or medical conditions or substance abuse, as well as educational, linguistic, and cross-cultural factors that may result in symptoms which resemble a psychological disability.
- Psycho-Educational or Neuropsychological Assessments are often necessary to support the need for accommodations because of the potential for psychological conditions to interfere with cognitive performance.
- Documentation may be provided from more than one source when a clinical team approach consisting of a variety of educational, medical, and counseling professionals has been used.
- Psychological **diagnoses documented by family members will not be accepted** due to professional and ethical considerations even when the family members are otherwise qualified by training and licensure/certification.
- If the disability co-exists with another condition, please refer to the appropriate documentation guidelines for additional information.
- The student's advisor and the Center for Disability & Access case management team will determine if the student qualifies for accommodations and what accommodations should be implemented.