



**Bellingham Technical College
Disability Support Services
Intake Assessment**

I intend to begin courses at Bellingham Technical College:

Summer Fall Winter Spring Year _____

Name _____ Date _____

Address _____

Phone _____ Email _____

Student ID Number _____ Date of Birth _____

Describe your disability:

Does your disability affect any of the following areas:

- | | | |
|-------------------|--------------------------|-----------------------------|
| ___ Reading | ___ Writing | ___ Mathematics |
| ___ Memory/Recall | ___ Reasoning/Processing | ___ Attention/Concentration |
| ___ Organization | ___ Mobility | ___ Social Adaptation |

What are your educational goals?

- | | |
|----------------------------|----------------------------|
| ___ Program Completion | ___ Certificate Completion |
| ___ GED | ___ Skill Building |
| ___ Other (Describe) _____ | |

Are you taking any medication that we should be aware of? Yes _____ No _____

Any side effects? _____

Are you currently seeing a doctor concerning your disability? Yes _____ No _____

Name of Doctor: _____ Phone Number: _____

Are you presently employed? Yes _____ No _____ Full time ____ Part time ____

Name of Employer: _____

Are you receiving financial aid? Yes _____ No _____ Date Applied _____

Are you a: Pathways to Health Student _____ I-BEST Student _____ Work First _____
Running Start Student _____ Which High School? _____

Are you a client of an agency?

DVR _____ DSHS _____ L&I _____ Work Source _____ Other _____

Caseworker: _____ Phone Number: _____

What classroom accommodations or academic adjustments, if any, are you requesting?

OFFICE USE ONLY		
Documentation On File _____	FERPA on file _____	DSS Code _____
Career Center Tracking _____	Entered in HP _____	
<u>Assessment Scores:</u>	Accommodations Given? _____	Equipment? _____
Rdg _____ Math _____		
Alg _____ SS _____		