

**West Valley College**  
**DESP APPLICATION FOR SERVICES**  
Disability and Educational Support Program

Initial Date of Application: \_\_\_\_\_ ID#: \_\_\_\_\_

Name: \_\_\_\_\_ Telephone#: \_\_\_\_\_

**DESP Program Overview:**

*DESP provides educational services and access for eligible students with documented disabilities who intend to pursue coursework at West Valley College. A variety of programs and services are available which afford eligible students with disabilities the opportunity to participate fully in all aspects of college programs and activities through appropriate and reasonable accommodations. Completion of this form constitutes an agreement to apply for Disability and Educational Support Program/DESP.*

**Student Responsibilities:**

1. I will provide the Disability and Educational Support Program with the information, documentation and/or forms (medical, educational, etc.) deemed necessary by DESP to verify my disability(ies).
2. I will meet with a Disability and Educational Support Program professional to complete a Student Educational Contract, and agree to meet with the professional at least annually to update the Student Educational Contract.
3. I will utilize the Disability and Educational Support Program in a responsible manner. I understand that the Disability and Educational Support Program uses written service provision policies and procedures, found in the DESP Student Handbook ([westvalley.edu/desp/forms.html](http://westvalley.edu/desp/forms.html)) that must be adhered to for continuation of services.
4. I will comply with the Student Code of Conduct adopted by the college.
5. I will make measurable progress toward the goals established in my Educational Contract and meet academic standards established by the college.

**Student Rights:**

1. All records maintained by DESP personnel pertaining to students with disabilities are protected from disclosure and are subject to all other requirements for handling of student records.
2. Participation by students with disabilities in DESP is entirely voluntary.
3. Receiving support services from DESP does not prevent a student from participating in any other courses, programs or activities.

*I understand that I must fulfill the requirements for participation in the DESP Program. I understand the consequences of failing to comply with the rules for responsible use of DESP services. I understand that I will be notified in writing before any action is taken to suspend services. By signing this application I affirm that I understand and agree with the DESP Program responsibilities of students and I will abide by them.*

Student Signature Date
DESP Specialist Signature Date

The Community College District uses the information requested on this form for the purpose of determining a student's eligibility to receive authorized special services provided by the Disabled Students Programs and Services (DSP&S) Program. Personal information recorded on this form will be kept confidential in order to protect against unauthorized disclosure. Portions of this information may be shared with the Chancellor's Office of the California Community Colleges or other state or federal agencies; however, disclosure to these parties is made in strict accordance with applicable statutes regarding confidentiality, including the Family Educational Rights and Privacy Act (20 U.S.C. 1232(g)). Pursuant to Section 7 of the Federal Privacy Act (Public Law 93-579; 5 U.S.C. § 552a, note), providing your social security number is voluntary. The information on this form is being collected pursuant to California Education Code Sections 67310-67312, and 84850; and California Code of Regulations, Title 5, Section 56000 et seq.

DESCRIPTIVE INFORMATION

Name (Print) \_\_\_\_\_

Date \_\_\_\_\_

Address \_\_\_\_\_

Home Phone \_\_\_\_\_

City \_\_\_\_\_ Zip \_\_\_\_\_

Cell Phone \_\_\_\_\_

Can you be contacted at work?  Yes  No

Work Phone \_\_\_\_\_

Gender \_\_\_\_\_ Date of Birth \_\_\_\_\_

Place of Birth \_\_\_\_\_

List name of person to notify in case of emergency during the weekdays:

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Cell Phone \_\_\_\_\_

REFERRAL INFORMATION

Who referred you to our program? \_\_\_\_\_ (Name) \_\_\_\_\_ (Agency)

Please check any disabilities that may apply to you:

- Visual Impairment
- Deaf/Hard of Hearing (circle one)
- Speech/Language Communication
- Acquired Brain Injury
- Learning Disability
- Developmentally Delayed Learner
- Mobility
- Psychological
- Other Health Conditions \_\_\_\_\_

At what age did your disability occur? \_\_\_\_\_. How does your disability impact your learning?

Are you on any medication at the present time? Yes \_\_\_\_\_ No \_\_\_\_\_

If any, please list: \_\_\_\_\_

Do you have a high school diploma? Yes \_\_\_\_\_ No \_\_\_\_\_

Other Colleges attended \_\_\_\_\_ Units earned \_\_\_\_\_

Please list any academic accommodations previously received:

Have you received Special Education Services in the past?

- Resource Specialist Program (RSP)
- Special Day Class (SDC)
- Other \_\_\_\_\_

Are you a client of any of the following agencies?

- Department of Rehabilitation
- Regional Center
- VA Rehab
- County Mental Health