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 certificated staff to complete an
Academic Accommodation Plan, and agree to meet with the certificated staff at least once a
semester to update it as necessary.
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 (www.westvalley.edu/desp/)
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 Academic Accommodation
Plan 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 Certificated Staff  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 ____________________________ City ____________________________ Zip ____________
Home Phone ____________ Cell Phone ____________ E-mail ____________________________
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, EDUCATIONAL AND MEDICAL INFORMATION

Who referred you to our program ____________________________
(Name) ____________________________ (Agency) ____________________________
Please describe your disability: ____________________________________________
______________________________________________________________________
At what age did your disability occur? ____________________________
How does your disability impact your learning? ______________________________________
______________________________________________________________________
______________________________________________________________________
Please list any academic accommodations that have been helpful: ____________________________
______________________________________________________________________
Are you on any medication at the present time? Yes______ No ______
If any, please list: _________________________________________________________
Do you have a high school diploma? Yes___ No___ High School Attended ____________
Other Colleges attended ____________________________ Units earned ____________________________
Have you received Special Education Services in the past? Please check all that apply
 Resource Specialist Program (RSP)  Special Day Class (SDC)  Other ____________________________
Are you a client of any of the following agencies? Please check all that apply:
 Department of Rehabilitation  Regional Center  VA Rehab  County Mental Health
Counselor’s Name: ____________________________

May 2016