



**Office of Accessible Education**  
 275 Eastland Road  
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 Email: [disability@bw.edu](mailto:disability@bw.edu)  
 Fax: (440) 826-3832

## Autism Spectrum Disorder (ASD) Verification Form

The Office of Accessible Education (OAE) provides services and accommodations for students with diagnosed disabilities. The documentation provided must demonstrate a disability covered under Section 504 of the Rehabilitation Act of 1973 and Title II of the Americans with Disabilities Act (ADA) of 1990. The ADA defines a disability as a physical or mental impairment that substantially limits one or more major life activity. For a student to be considered eligible to receive reasonable accommodations, the documentation must show the functional limitations that impact the individual in the post-secondary setting.

OAE requires current and comprehensive documentation to determine appropriate services and accommodations. As a guideline, Baldwin Wallace University generally requires documentation prepared within the last 36 months (3 years). The University reserves the right to request updated or more extensive documentation as appropriate. The information outlined below is necessary to evaluate eligibility for accommodations.

- The professional(s) conducting the assessment, rendering a diagnosis, and providing recommendations for reasonable accommodations must be qualified to do so. These persons generally are trained, certified or licensed physicians, psychiatrists, clinical psychologists, or neurologists.
- All parts of the form must be completed as thoroughly as possible.
- The provider should attach any reports which provide additional, related information. A copy of a relevant evaluation report may be submitted as documentation, in lieu of this form, as long as it is comprehensive, current, and meets all of the documentation requirements as outlined in the Baldwin Wallace University General Guidelines for Documentation, available at <http://www.bw.edu/accessible-education>.
- The information provided on this form is NOT part of the student’s permanent educational record, but will be maintained with OAE.

### STUDENT INFORMATION (Please Print)

Name (Last, First, Middle): \_\_\_\_\_

Date of Birth: \_\_\_\_\_ BW ID Number: \_\_\_\_\_

Status (check one):     current student                       transfer student                       prospective student

Phone: ( \_\_\_\_\_ ) \_\_\_\_\_ - \_\_\_\_\_                      BW Email: \_\_\_\_\_@bw.edu

Address (street, city, state, zip code): \_\_\_\_\_

\_\_\_\_\_

By signing below, the student grants OAE permission to contact the provider for additional information.

I, \_\_\_\_\_ (printed name of student), hereby authorize OAE to obtain and/or release information from/to the undersigned provider in order to evaluate eligibility for accommodations.

Student Signature: \_\_\_\_\_ Date: \_\_\_\_\_

### DIAGNOSTIC INFORMATION (Please Print)

1. Date of initial contact with the student: \_\_\_\_\_

2. Date of last contact with the student: \_\_\_\_\_

3. Does the student have a clinical history of ASD symptoms?

Yes

No

4. Approximately at what age or grade did the student start to exhibit ASD symptoms? \_\_\_\_\_

5. What date was the student diagnosed with ASD? \_\_\_\_\_

6. Provide information regarding the student's current presenting symptoms with regard to the following:

social interaction, reciprocal verbal communication, shared emotions and affect	
nonverbal communication	
restricted, repetitive patterns of motor behavior, stereotypes	
inflexible adherence to routines	
hyper- or hypo-reactivity to sensory input	

7. DSM-V Diagnosis(es) or rule-out diagnoses (Include the principal diagnosis and code for each): \_\_\_\_\_

8. What are the student's functional limitations, attributable to ASD? How does the impairment affect the student's performance? \_\_\_\_\_

9. What is the severity of the disorder with regard to social communication impairments and restricted, repetitive patterns of behavior, based on the DSM-5 severity rating scale (below)?

Social Communication:  Level 1  Level 2  Level 3  
 Restricted Interests & Repetitive Behaviors:  Level 1  Level 2  Level 3

Social Communication	Restricted Interests & Repetitive Behaviors
<b>Requiring support (Level 1):</b> Without supports in place, deficits in social communication cause noticeable impairments. Difficulty initiating social interactions, and clear examples of atypical or unsuccessful responses to social overtures of others. May appear to have decreased interest in social interactions.	<b>Requiring support (Level 1):</b> Inflexibility of behavior causes significant interference with functioning in one or more contexts. Difficulty switching between activities. Problems of organization and planning hamper independence.
<b>Requiring substantial support (Level 2):</b> Marked deficits in verbal and nonverbal social communication skills; social impairments apparent even with supports in place; limited initiation of social interactions; and reduced or abnormal responses to social overtures from others.	<b>Requiring substantial support (Level 2):</b> Inflexibility of behavior, difficulty coping with change, or other restricted/repetitive behaviors appear frequently enough to be obvious to the casual observer and interfere with functioning in a variety of contexts. Distress and/or difficulty changing focus or action.
<b>Requiring very substantial support (Level 3):</b> Severe deficits in verbal and nonverbal social communication skills cause severe impairments in functioning, very limited initiation of social interactions, and minimal response to social overtures from others.	<b>Requiring very substantial support (Level 3):</b> Inflexibility of behavior, extreme difficulty coping with change, or other restricted/repetitive behaviors markedly interfere with functioning in all spheres. Great distress/difficulty changing focus or action.

10. Did you use an ASD-specific behavioral evaluation, ASD rating scale or checklist to obtain information about the student's symptoms and functioning in various settings?  
 Yes  No

If yes, which ASD behavioral evaluation, rating scale(s) or checklist(s) did you use? \_\_\_\_\_

\_\_\_\_\_

If no, how did you reach your conclusion about the ASD diagnosis and treatment? \_\_\_\_\_

\_\_\_\_\_

11. Provide information regarding the student's global intellectual functioning and current academic functioning as measured by aptitude and achievement tests respectively. If the information is contained within a neuropsychological or psychoeducational evaluative report, include the report with this Verification Form.

**Aptitude:** List (a) the name of the comprehensive and current aptitude/cognitive instrument administered; (b) the standard scores per subtest; and (c) the percentiles per subtest: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Achievement:** List (a) the name of the comprehensive and current achievement battery administered; (b) the standard scores per academic area subtest; and (c) the percentiles per academic area subtest: \_\_\_\_\_

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12. Major Life Activities Assessment:

Select which of the following major life activities listed below may be affected because of the impairment. Indicate the degree to which each activity is impacted.

Life Activity	Negligible	Moderate	Substantial	Unknown
Concentrating				
Memory				
Eating				
Social Interactions				
Self-Care				
Stress Management				
Managing Internal Distractions				
Managing External Distractions				
Sleeping				
Organizing				

13. Describe situations or environmental conditions that might lead to an exacerbation of the condition: \_\_\_\_\_

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14. Does the student currently take medication(s) for ASD symptoms (list medication, dosage, frequency)? If yes, how might side effects impact the student's functioning? \_\_\_\_\_

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15. State specific recommendations regarding reasonable accommodations for this student, and a rationale as to why these accommodations, adjustments, or services are warranted based upon the student's functional limitations. Indicate why each accommodation is necessary: \_\_\_\_\_

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**PROVIDER INFORMATION**

*Print, sign, date and complete all fields below*

By selecting this box, I am verifying that the named student information is correct, that the student is a patient that I have been treating, and that **I am not a relative of the student.**

Provider Name (Print): \_\_\_\_\_ Date: \_\_\_\_\_

Provider Signature: \_\_\_\_\_

Title: \_\_\_\_\_

License or Certification #: \_\_\_\_\_

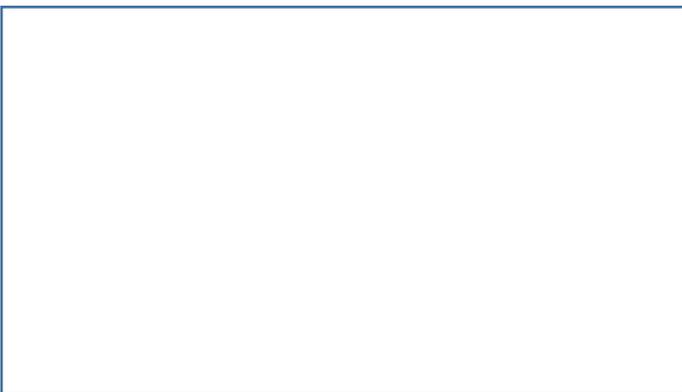
Mailing Address: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Phone: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Fax: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Email: \_\_\_\_\_

*The student signed a Consent for Release of Information on page 1 of this form. We may reach out to you directly for more information or clarification to support the student's request for accommodations.*

You may affix a business card in the space below:



**Please complete this form in its entirety and submit it to:**

**Baldwin Wallace University  
Office of Accessible Education  
275 Eastland Road  
Berea, OH 44017  
Fax: (440) 826-3832  
Email: [disability@bw.edu](mailto:disability@bw.edu)**