



**Harvard University Division of Continuing Education**  
Harvard Extension School • Harvard Summer School  
51 Brattle Street, Cambridge, Massachusetts 02138-3722  
(617) 495-0977 (voice) • (617) 495-9419 (TTY)

# **Guidelines for Documentation**

## ***of Attention Deficit (Hyperactivity) Disorder AD(H)D***

### **Introduction**

Under the Americans with Disabilities Act (ADA) and Section 504 of the Rehabilitation Act of 1973, individuals with disabilities are protected from discrimination and may be entitled to reasonable accommodations and rights to equal access to programs and services. To establish that an individual is covered under the ADA, the documentation must indicate that the disability substantially limits one or more major life activity, and supports the request for accommodations, academic adjustments, and/or auxiliary aids. A diagnosis of a disorder/condition alone does not automatically qualify an individual for accommodations under the ADA.

These Guidelines are based on the AHEAD (Association on Higher Education and Disability) guidelines as recommended by the Consortium on AD(H)D Documentation © 1998. The mission of the Consortium was to develop standard criteria for documenting attention deficit disorders, with or without hyperactivity (AD(H)D). Modified versions of these guidelines can be used by postsecondary personnel, examining, certifying, and licensing agencies, and consumers who require documentation to determine reasonable and appropriate accommodation(s) for individuals with AD(H)D. Although the more generic term, Attention Deficit Disorder (ADD), is frequently used, the official nomenclature in the *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV-TR)* (American Psychiatric Association, © 2000) is Attention-Deficit/Hyperactivity Disorder (AD(H)D), which is used in these guidelines. The guidelines provide consumers, professional diagnosticians, and service providers with an understanding and knowledge base of the components of documentation that are necessary to validate the existence of AD(H)D, its impact on the individual's educational performance, and the need for accommodation(s). The information and documentation to be submitted should be comprehensive in order to avoid or reduce unnecessary time delays in decision-making related to the provision of services.

Clinical documentation of AD(H)D that is submitted to the Division of Continuing Education for the purpose of seeking accommodations is expected to meet the standards set forth in these guidelines. All clinical documentation is reviewed by the Division and its consultants, as required, to determine what, if any, accommodations are appropriate to the settings for which they are intended. Although a previous history of accommodation may provide valuable insight into the student's ability to integrate into a previous setting, the Division of Continuing Education makes independent judgment about Harvard settings and the appropriateness, if any, of accommodation requests.

In the main section of the document, the Consortium presents guidelines in four important areas:

- 1) Qualifications of the evaluator;
- 2) Recency of documentation;
- 3) Comprehensiveness of the documentation to substantiate the AD(H)D; and
- 4) Evidence to establish a rationale to support the need for accommodation(s).

Appendix A provides diagnostic criteria for AD(H)D reprinted with permission from the *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision (DSM-IV-TR)*, Copyright 2000 American Psychiatric Association. Appendices B, C, and D provide recommendations for consumers, suggestions for assessment, and a listing of resources and organizations, respectively.

This document provides guidelines necessary to establish the impact of AD(H)D disabilities on the individual's educational performance and participation in other University programs and activities, and to validate the need for

accommodations. The two official nomenclatures designed to outline the criteria used in making these diagnoses are the *Diagnostic and Statistical Manual* (DSM-IV-TR) and the ICD-10 (*The International Statistical Classification of Diseases and Related Health Problems, Tenth Revision, published by the World Health Organization*). In instances where there may be multiple diagnoses including learning disabilities and psychiatric disabilities, evaluators should consult the appropriate companion guidelines available from the Division of Continuing Education.

Information and documentation submitted by students to verify accommodation eligibility must be comprehensive in order to avoid unnecessary delays in decision making related to the provision of requested accommodations.

## Documentation Guidelines

### I. A Qualified Professional Must Conduct the Evaluation

Professionals conducting assessments and rendering diagnoses of AD(H)D must have training in differential diagnosis and the full range of psychiatric disorders. The name, title, and professional credentials of the evaluator, including information about license or certification as well as the area of specialization, employment, and state or province in which the individual practices, should be clearly stated in the documentation. The following professionals would generally be considered qualified to evaluate and diagnose AD(H)D provided they have comprehensive training in the differential diagnosis of AD(H)D and direct experience with an adolescent or adult AD(H)D population: clinical psychologists, neuropsychologists, psychiatrists, and other relevantly trained medical doctors. It may be appropriate to use a clinical team approach consisting of a variety of educational, medical, and counseling professionals with training in the evaluation of AD(H)D in adolescents and adults.

Use of diagnostic terminology indicating an AD(H)D by someone whose training and experience are not in these fields is not acceptable. It is also not appropriate for professionals to evaluate members of their own families. All reports should be on letterhead, typed, dated, signed, and otherwise legible. The receiving institution or agency has the responsibility to maintain the confidentiality of the individual's records.

### II. Documentation Must be Current

Because the provision of all reasonable accommodations and services is based upon assessment of the current impact of the disability on academic performance, it is in an individual's best interest to provide recent and appropriate documentation. In most cases, this means that a diagnostic evaluation has been completed within the past three years. Flexibility in accepting documentation that exceeds a three-year period may be important under certain conditions if the previous assessment is applicable to the current or anticipated setting. If documentation is inadequate in scope or content, or does not address the individual's current level of functioning and need for accommodation(s), reevaluation may be warranted. Furthermore, observed changes may have occurred in the individual's performance since previous assessment, or new medication(s) may have been prescribed or discontinued since the previous assessment was conducted. In such cases, it may be necessary to update the evaluation report. The update should include a detailed assessment of the current impact of the AD(H)D and interpretive summary of relevant information and the previous diagnostic report.

### III. Documentation Should be Comprehensive

#### A. Evidence of Early Impairment

Because AD(H)D is, by definition, first exhibited in childhood (although it may not have been formally diagnosed) and manifests itself in more than one setting, relevant historical information is essential. The following should be included in a comprehensive assessment: clinical summary of objective, historical information establishing symptomology indicative of AD(H)D throughout childhood, adolescence, and adulthood as garnered from transcripts, report cards, teacher comments, tutoring evaluations, past psychoeducational testing, and third party interviews when available.

#### B. Evidence of Current Impairment

In addition to providing evidence of a childhood history of impairment, the following areas must be investigated:

## Guidelines for Documentation of Attention Deficit (Hyperactivity) Disorder AD(H)D

### 1. Statement of Presenting Problem

A history of the individual's presenting attentional symptoms should be provided, including evidence of ongoing impulsive/hyperactive or inattentive behaviors that significantly impair functioning in two or more settings.

### 2. Diagnostic Interview

The information collected for the summary of the diagnostic interview should consist of more than self-report, as information from third party sources is critical in the diagnosis of AD(H)D. The diagnostic interview with information from a variety of sources should include, but not necessarily be limited to, the following:

- History of presenting attentional symptoms, including evidence of ongoing impulsive/hyperactive or inattentive behavior that has significantly impaired functioning over time.
- Developmental history.
- Family history for presence of AD(H)D and other educational, learning, physical, or psychological difficulties deemed relevant by the examiner.
- Relevant medical and medication history, including the absence of a medical basis for the symptoms being evaluated.
- Relevant psychosocial history and any relevant interventions.
- A thorough academic history of elementary, secondary, and postsecondary education.
- Review of prior psychoeducational test reports to determine whether a pattern of strengths or weaknesses is supportive of attention or learning problems.
- Relevant employment history.
- Description of current functional limitations pertaining to an educational setting that are presumably a direct result of problems with attention.
- Relevant history of prior therapy.

### *C. Rule Out Alternative Diagnoses or Explanations*

The evaluator must investigate and discuss the possibility of dual diagnoses, and alternative or co-existing mood, behavioral, neurological, and/or personality disorders that may confound the diagnosis of AD(H)D. This process should include exploration of possible, alternative diagnoses, and medical and psychiatric disorders as well as educational and cultural factors impacting the individual that may result in behaviors mimicking an Attention-Deficit/Hyperactivity Disorder.

### *D. Relevant Testing Information Must be Provided*

The assessment of the individual must not only establish a diagnosis of AD(H)D, but must also demonstrate the current impact of the AD(H)D on an individual's ability to take standardized tests. In addition, neuropsychological or psychoeducational assessment is important in determining the current impact of the disorder on an individual's ability to function in academically related settings. The evaluator must objectively review and include with the evaluation report relevant background information to support the diagnosis and its impact within the current educational environment. If grade equivalents are reported, they must be accompanied by standard scores and/or percentiles.

Test scores or subtest scores alone should not be used as a sole measure for the diagnostic decision regarding AD(H)D. Selected subtest scores from measures of intellectual ability, memory functions tests, attention or tracking tests, or continuous performance tests do not in and of themselves establish the presence or absence of AD(H)D. Checklists and/or surveys can serve to supplement the diagnostic profile but in and of themselves are not adequate for the diagnosis of AD(H)D and do not substitute for clinical observations and sound diagnostic judgment. All data must logically reflect a substantial limitation to learning for which the individual is requesting accommodation.

*E. Identification of DSM-IV-TR Criteria*

According to the DSM-IV-TR, “the essential feature of AD(H)D is a persistent pattern of inattention and/or hyperactivity-impulsivity that is more frequent and severe than is typically observed in individuals at a comparable level of development” (p. 85). A diagnostic report should include a review and discussion of the DSM-IV-TR criteria for AD(H)D both currently and retrospectively and specify which symptoms are present (see Appendix A for DSM-IV-TR criteria). In diagnosing AD(H)D, it is particularly important to address the following criteria: symptoms of hyperactivity/impulsivity or inattention that cause impairment which must have been present in childhood; current symptoms that have been present for at least the past six months; impairment from the symptoms present in two or more settings (for example, school, work, and home); clear evidence of significant impairment in social, academic, or occupational functioning; and symptoms that do not occur exclusively during the course of a Pervasive Developmental Disorder, Schizophrenia, or other Psychotic Disorder and are not better accounted for by another mental disorder (e.g., Mood Disorder, Anxiety Disorder, Dissociative Disorder, or a Personality Disorder).

*F. Documentation Must Include a Specific Diagnosis*

The report must include a specific diagnosis of AD(H)D based on the DSM-IV diagnostic criteria. The diagnostician should use direct language in the diagnosis of AD(H)D, avoiding the use of terms such as “suggests,” “is indicative of,” or “attention problems.” Individuals who report only problems with organization, test anxiety, memory, and concentration in selective situations do not fit the proscribed diagnostic criteria for AD(H)D. Given that many individuals benefit from prescribed medications and therapies, a positive response to medication by itself does not confirm a diagnosis, nor does the use of medication in and of itself either support or negate the need for accommodation(s).

*G. An Interpretative Summary Should Be Provided*

A well-written interpretative summary based on a comprehensive evaluative process is a necessary component of the documentation. Because AD(H)D is in many ways a diagnosis that is based upon the interpretation of historical data and observation, as well as other diagnostic information, it is essential that professional judgment be utilized in the development of a summary, which should include:

- Demonstration of the evaluator having ruled out alternative explanations for inattentiveness, impulsivity, and/or hyperactivity as a result of psychological or medical disorders or non-cognitive factors.
- Indication of how patterns of inattentiveness, impulsivity, and/or hyperactivity across the life span and across settings are used to determine the presence of AD(H)D.
- Indication of whether or not the student was evaluated while on medication, and whether or not there is a positive response to the prescribed treatment.
- Indication and discussion of the substantial limitation to learning presented by the AD(H)D and the degree to which it impacts the individual in the learning context for which accommodations are being requested. Indication as to why specific accommodations are needed and how the effects of AD(H)D symptoms, as designated by the DSM-IV-TR, are mediated by the accommodation(s).

**IV. Each Accommodation Recommendation by the Evaluator Should Include a Rationale**

The evaluator(s) should describe the impact, if any, of the diagnosed AD(H)D on a specific major life activity as well as the degree of impact on the individual. The diagnostic report should include specific recommendations for accommodations that are realistic and that postsecondary institutions, examining, certifying, and licensing agencies can reasonably provide. A detailed explanation should be provided as to why each accommodation is recommended and should be correlated with specific functional limitations determined through interview, observation, and/or testing. Although prior documentation may have been useful in determining appropriate services in the past, current documentation should validate the need for services based on the individual’s present level of functioning in the educational setting. A school plan such as an Individualized Education Program (IEP) or a 504 plan is insufficient documentation in and of itself but can be included as part of a more comprehensive evaluative

report. The documentation should include any record of prior accommodations or auxiliary aids, including information about specific conditions under which the accommodations were used (e.g., standardized testing, final exams, licensing or certification examinations) and whether or not they benefited the individual. However, a prior history of accommodations, without demonstration of a current need, does not in itself warrant the provision of a like accommodation. If no prior accommodations were provided, the qualified professional and/or the individual should include a detailed explanation as to why no accommodations were used in the past and why accommodations are needed at this time.

Because of the challenge of distinguishing normal behaviors and developmental patterns of adolescents and adults (e.g., procrastination, disorganization, distractibility, restlessness, boredom, academic underachievement or failure, low self-esteem, and chronic tardiness or inattendance) from clinically significant impairment, a multifaceted evaluation should address the intensity and frequency of the symptoms and whether these behaviors constitute an impairment in a major life activity.

If an accommodation(s) is not clearly identified in the diagnostic report, the Division of Continuing Education will seek clarification, and, if necessary, more information. The Division of Continuing Education will make the determination as to whether appropriate and reasonable accommodations are warranted and can be provided to the individual.

#### **V. Accountability and Confidentiality**

Reasonable accommodation(s) may help to ameliorate the disability and to minimize its impact on the student's clinically documented difficulties in this particular setting. The determination for reasonable accommodation(s) rests with the Division of Continuing Education in collaboration with the individual with the disability and, when appropriate, faculty, all of whom have a responsibility to maintain confidentiality of any information. The student is responsible for obtaining and providing the Division of Continuing Education with all relevant materials in a timely manner. The Division of Continuing Education may not release any part of the documentation without the individual's informed consent, except in the case of a court ordered subpoena. If the requested accommodations are not clearly identified in the diagnostic report, the Division of Continuing Education reserves the right to seek additional clinical information pertaining to determination of eligibility for requested accommodations.

## Appendix A—DSM-IV-TR Diagnostic Criteria for AD(H)D

Permission is required to reproduce the *DSM-IV-TR*. The following excerpt, that comprises appendix A, is reprinted with permission from the *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision*, Washington, DC, American Psychiatric Association, 2000, pp. 92–93.

### Diagnostic criteria for Attention-Deficit/Hyperactivity Disorder

A. Either (1) or (2):

- (1) Six (or more) of the following symptoms of **inattention** have persisted for at least 6 months to a degree that is maladaptive and inconsistent with developmental level:

#### *Inattention*

- (a) Often fails to give close attention to details or makes careless mistakes in schoolwork, work, or other activities
- (b) Often has difficulty sustaining attention in tasks or play activities
- (c) Often does not seem to listen when spoken to directly
- (d) Often does not follow through on instructions and fails to finish schoolwork, chores, or duties in the workplace (not due to oppositional behavior or failure to understand instructions)
- (e) Often has difficulty organizing tasks and activities
- (f) Often avoids, dislikes, or is reluctant to engage in tasks that require sustained mental effort (such as schoolwork or homework)
- (g) Often loses things necessary for tasks or activities (e.g., toys, school assignments, pencils, books, or tools)
- (h) Is often easily distracted by extraneous stimuli
- (i) Is often forgetful in daily activities

- (2) Six (or more) of the following symptoms of **hyperactivity-impulsivity** have persisted for at least 6 months to a degree that is maladaptive and inconsistent with developmental level:

#### *Hyperactivity*

- (a) Often fidgets with hands or feet or squirms in seat
- (b) Often leaves seat in classroom or in other situations in which remaining seated is expected
- (c) Often runs about or climbs excessively in situations in which it is inappropriate (in adolescents or adults, may be limited to subjective feelings of restlessness)
- (d) Often has difficulty playing or engaging in leisure activities quietly
- (e) Is often “on the go” or often acts as if “driven by a motor”
- (f) Often talks excessively

#### *Impulsivity*

- (g) Often blurts out answers before questions have been completed
- (h) Often has difficulty awaiting turn
- (i) Often interrupts or intrudes on others (e.g., butts into conversations or games)

B. Some hyperactive-impulsive or inattentive symptoms that caused impairment were present before age 7 years.

C. Some impairment from the symptoms is present in two or more settings (e.g., at school [or work] and at home).

D. There must be clear evidence of clinically significant impairment in social, academic, or occupational functioning.

E. The symptoms do not occur exclusively during the course of a Pervasive Developmental Disorder, Schizophrenia, or other Psychotic Disorder and are not better accounted for by another mental disorder (e.g., Mood Disorder, Anxiety Disorder, Dissociative Disorder, or a Personality Disorder).

The *DSM-IV-TR* specifies a code designation based on type:

**314.01 Attention-Deficit/Hyperactivity Disorder, Combined Type:**

if both Criteria A1 and A2 are met for the past 6 months.

**314.00 Attention-Deficit/Hyperactivity Disorder, Predominantly Inattentive Type:**

if Criterion A1 is met but Criterion A2 is not met for the past 6 months.

**314.01 Attention-Deficit/Hyperactivity Disorder, Predominantly Hyperactive-Impulsive Type:**

if Criterion A2 is met but Criterion A1 is not met for the past 6 months.

**Coding note:** For individuals (especially adolescents and adults) who currently have symptoms that no longer meet full criteria, “In Partial Remission” should be specified.

### **314.9 Attention Deficit/Hyperactivity Disorder Not Otherwise Specified**

This category is for disorders with prominent symptoms of inattention or hyperactivity-impulsivity that do not meet criteria for Attention-Deficit/Hyperactivity Disorder.

Examples include

1. Individuals whose symptoms and impairment meet the criteria for Attention-Deficit/Hyperactivity Disorder, Predominately Inattentive Type but whose age at onset is 7 years or after
2. Individuals with clinically significant impairment who present with inattention and whose symptom pattern does not meet the full criteria for the disorder but have a behavioral pattern marked by sluggishness, daydreaming, and hypoactivity

## **Appendix B—Recommendations for Consumers**

### **For assistance in finding a qualified professional:**

Contact the disability services coordinator at a college or university for possible referral sources; and/or contact a physician who may be able to refer you to a qualified professional with demonstrated expertise in AD(H)D.

### **In selecting a qualified professional:**

- Ask what experience and training he or she has had diagnosing adolescents and adults;
- Ask whether he or she has training in differential diagnosis and the full range of psychiatric disorders. Clinicians typically qualified to diagnose AD(H)D may include clinical psychologists, physicians, including psychiatrists, and neuropsychologists;
- Ask whether he or she has ever worked with a postsecondary disability service provider or with the agency to whom you are providing documentation;
- And ask whether you will receive a comprehensive written report.

### **In working with the professional:**

- Take a copy of these guidelines to the professional;
- And be prepared to be forthcoming, thorough, and honest with requested information.

### **As follow-up to the assessment by the professional:**

- Schedule a meeting to discuss the results, recommendations, and possible treatment;
- Request additional resources, support group information, and publications if you need them;
- Maintain a personal file of your records and reports;
- And be aware that any receiving institution or agency has a responsibility to maintain confidentiality.

## Appendix C—Suggestions for Assessment

The diagnosis of AD(H)D is strongly dependent on a clinical interview in conjunction with a variety of formal and informal measures. Since there is no one test, or specified combination of tests, for determining AD(H)D, the diagnosis of an attention deficit/hyperactivity disorder (AD(H)D) requires a multifaceted approach. Any tests that are selected by the evaluator should be technically accurate, reliable, valid, and standardized on the appropriate norm group. The following list includes five broad domains that are frequently explored when arriving at an AD(H)D diagnosis. This listing is provided as a helpful resource but is not intended to be definitive or exhaustive.

### 1. Clinical interview

The evaluator should:

- 1) Provide retrospective confirmation of AD(H)D;
- 2) Establish relevant developmental and academic markers;
- 3) Determine any other co-existing disorders; and
- 4) Rule out other problems that may mimic AD(H)D.

Specific areas to be addressed include:

- Family history
- Results of a neuro-medical history
- Presence of AD(H)D symptoms since childhood
- Presence of AD(H)D symptoms in last 6 months
- Evidence that symptoms cause a “significant impairment” over time
- Results of clinical observation for hyperactive behavior, impulsive speech, distractibility
- Extent of functional impairment across settings (e.g., academic, occupational, social)
- An accounting for periods in which student was symptom-free
- Presence of other psychiatric conditions (mood or anxiety disorders, substance abuse, etc.)
- Indication that symptoms are not due to other conditions (e.g., depression, drug use, neuromedical problems)
- Relevant medication history
- Determination of which remediation approaches and/or compensating strategies are and are not currently effective
- Determination of what accommodations, if any, have alleviated symptoms in the past or in the present setting

### 2. Rating scales

Self-rater or interviewer-rated scales for categorizing and quantifying the nature of the impairment may be useful in conjunction with other data.

Selected examples include:

- Wender Utah Rating Scale
- Brown Attention-Activation Disorder Scale
- Beck Anxiety Inventory
- Hamilton’s Depression Rating Scale
- Conners Teacher Rating Scale (age 3–17 years)
- Conners Parent Rating Scale (age 3–17 years)

### 3. Neuro-psychological and psycho-educational testing

Cognitive and achievement profiles may suggest attention or information processing deficits. No single test or subtest should be used as the sole basis for a diagnostic decision. Acceptable documents include, but are not limited to:

#### Aptitude/Cognitive Ability

- Wechsler Adult Intelligence Scale—III (WAIS-III)
- Woodcock-Johnson Psychoeducational Battery—Revised: Tests of Cognitive Ability
- Kaufman Adolescent and Adult Intelligence Test

#### Academic Achievement

- Scholastic Abilities Test for Adults (SATA)
- Stanford Test of Academic Skills (TASK)
- Woodcock-Johnson Psychoeducational Battery—Revised: Tests of Cognitive Achievement
- Wechsler Individual Achievement Test (WIAT)

or specific achievement tests such as

- Nelson-Denny Reading Skills Test
- Stanford Diagnostic Mathematics Test
- Test of Written Language—3 (TOWL-3)
- Woodcock Reading Master Tests—Revised

#### Information Processing

- Detroit Tests of Learning Aptitude—3 (DTLA-3) or Detroit Tests of Learning Aptitude—Adult (DTLA-A).
- Information from subtests on WAIS-R or Woodcock-Johnson Psychoeducational Battery—Revised: Tests of Cognitive Ability,
- as well as other relevant instruments, may be useful when interpreted within the context of other diagnostic information.

### 4. Medical evaluation

Medical disorders may cause symptoms resembling AD(H)D. Therefore, it may be important to rule out the following:

- Neuroendocrine disorders (e.g., thyroid dysfunction)
- Neurologic disorders
- Impact of medication on attention if tried, and under what circumstances

### 5. Collateral information

Include third party sources that can be helpful to determine the presence or absence of AD(H)D in childhood:

- Description of current symptoms (e.g., by spouse, teachers, employer)
- Description of childhood symptoms (e.g., by parent)
- Information from old school and report cards and transcripts

## Appendix D—Resources and Organizations

### **Association on Higher Education and Disability (AHEAD)**

University of Mass Boston  
100 Morrissey Blvd.  
Boston, MA 02125-3393  
(617) 287-3880 voice/TTY  
(617) 287-3881 FAX  
[www.AHEAD.org](http://www.AHEAD.org)

An excellent organization to contact for individuals with disabilities who are planning to attend college and who will need accommodations. Numerous training programs, workshops, publications, and conferences.

### **Children and Adults with Attention Deficit Disorders (CHADD)**

8181 Professional Place, Suite 201  
Landover, MD 20785  
(800) 233-4050 voice (toll free)  
(301) 306-7070 voice  
(301) 306-7090 FAX  
[www.chadd.org](http://www.chadd.org)

CHADD is a national organization with over 32,000 members and more than 500 chapters nationwide that provides support and information for parents who have children with ADD and adults with ADD.

### **Council for Exceptional Children**

1920 Association Drive  
Reston, VA 22091-1589  
(888) CEC-SPED voice (toll free)  
(703) 620-3660 voice  
(703) 264-9446 TTY  
(703) 264-9494 FAX  
[www.cec.sped.org](http://www.cec.sped.org)

The largest international professional organization committed to improving educational outcomes for individuals with disabilities.

### **HEALTH Resource Center**

American Council on Education  
One Dupont Circle NW, Suite 800  
Washington, DC 20036-1193  
(800) 544-3284 voice (toll free)  
(202) 939-9300 voice/TTY  
(202) 833-4760 FAX  
[www.acenet.edu/About/programs/Access&Equity/HEATH/home.html](http://www.acenet.edu/About/programs/Access&Equity/HEATH/home.html)

A clearinghouse of information on topics related to postsecondary education and disabilities. Publishes an annual resource directory.

### **International Dyslexia Association (IDA)**

8600 LaSalle Road  
Chester Building, Suite 382  
Baltimore, MD 21286-2044  
(410) 296-0232 voice  
(800) ABCD-123 messages  
(410) 321-5069 FAX  
[www.interdys.org](http://www.interdys.org)

The IDA is an international, nonprofit organization dedicated to the study and treatment of learning disabilities and dyslexia. For nearly 50 years, the IDA has been helping individuals with dyslexia, their families, teachers, physicians, and researchers to better understand dyslexia.

### **Learning Disabilities Association of America (LDA)**

4156 Library Road  
Pittsburgh, PA 15234-1349  
(412) 341-1515 voice  
(412) 344-0224 FAX  
[www.lदानatl.org](http://www.lदानatl.org)

LDA is the largest nonprofit volunteer organization advocating for individuals with learning

disabilities. LDA has more than 600 local chapters and affiliates in 50 states, Washington, DC, and Puerto Rico. LDA seeks to educate individuals with learning disabilities and their parents about the nature of the disability and inform them of their rights.

### **Recording for the Blind & Dyslexic (RFB&D)**

20 Roszel Road  
Princeton, NJ 08540  
(609) 452-0606 voice  
(800) 221-4792 voice (book orders only)  
(609) 520-7990 FAX  
[www.rfbd.org](http://www.rfbd.org)

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