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Documentation Guidelines for Test Takers with Psychiatric Disabilities

Office of Disability Policy
2025

I. Preface

ETS recognizes the importance of periodic review of documentation guidelines to ensure that they reflect current practice and professional standards, developments in the field and recent guidance from the Department of Justice. This edition (2025) of the ETS Documentation Guidelines for Test Takers with Psychiatric Disabilities incorporates the previous editions and introduces other changes based upon many years of experience with test takers with psychiatric disabilities.

Definition:

"Psychiatric disabilities" refers to a range of conditions characterized by different types and degrees of developmental, emotional, psychological, cognitive, neurological and/or behavioral manifestations. The terms "psychiatric disabilities", "psychiatric disorders", and "psychiatric conditions" are used interchangeably within this document. The source for understanding the nature of these conditions is typically the most recent version of the Diagnostic and Statistical Manual of Mental Disorders (DSM; American Psychiatric Association) or the International Classification of Diseases: Classification of Mental and Behavioural Disorders (ICD; World Health Organization). Common categories of psychiatric conditions include but are not limited to: affective disorders (e.g., anxiety, depression, etc.); mood disorders (e.g., bipolar disorder, etc.); psychotic or thought disorders (e.g., schizophrenia, schizoaffective disorder, etc.); obsessive-compulsive and related disorders (e.g., obsessive-compulsive disorder, etc.); and stress disorders (e.g., post-traumatic stress disorder).

II. Introduction

ETS is committed to providing reasonable testing accommodations for test takers with documented disabilities as recognized under the ADA Amendments Act of 2008 (ADAAA). We review requests for accommodations on a case-by-case basis according to established policies and practices, which ensure that people with disabilities have equal access to ETS tests. This document provides guidance to test takers with psychiatric disabilities who are requesting accommodations. It also provides guidance to evaluators regarding the documentation of psychiatric disabilities and the linking of accommodation requests to disability-related functional limitations.

You may refer to https://www.ets.org/disabilities/test-takers.html for helpful information on requesting accommodations, registering for a test and scheduling a test date. You can also use the "For Test Takers" page for a list of common accommodations, information on where to find bulletins for the test(s) you plan to take, how to determine if documentation is needed to support requested accommodations, and how to register, pay for and schedule the test(s).

To provide more information for your evaluators or other relevant professionals, please direct them to https://www.ets.org/disabilities/evaluators.html.

III. Documentation Details

Who should conduct an evaluation and what identifying information is important?

Professionals conducting evaluations, rendering diagnoses of psychiatric conditions and making recommendations for accommodations of individuals with disabilities should be qualified to do so. In compiling accommodation documentation for test takers, professionals should provide a statement of professional qualification that includes: (1) information regarding their training and relevant expertise in the diagnosis of psychiatric disorders; and (2) their license/certification number and the jurisdictions within which they are licensed to practice.

Qualified evaluators are defined as those licensed individuals who are competent to evaluate and diagnose psychiatric disorders or who may serve as members of the diagnostic team. These individuals or team members may include but are not limited to: licensed psychologists, neuropsychologists, psychiatrists and other comparably trained medical doctors, clinical social workers, counselors, physician's assistants and nurse practitioners.

Documentation may be provided from more than one source when a clinical team approach consisting of a variety of educational, medical and mental health professionals has been used.

Diagnosis and documentation of psychiatric disorders by a family member will not be accepted. Professional standards indicate that such documentation is generally unethical, even when the family member is otherwise qualified by virtue of their training and licensure/certification.

The name, title and professional credentials of the evaluator should be clearly stated in the documentation. This information should include licensure and/or certification, as well as the areas of specialization, employment and the state or province in which the individual practices. If the evaluation was conducted by tele-assessment or via a hybrid of tele-assessment and in-person assessment, the following information should be included: which parts of the evaluation were conducted in person and which were conducted remotely; and, for assessments done remotely, the geographic location of the evaluator and the geographic location of the test taker at the time the evaluation was conducted. For additional information, please see ETS Tele-Assessment Guidance, https://www.ets.org/pdfs/disabilities/tele-assessment-guidance.pdf. All reports should be on letterhead, typed in English, dated, signed and otherwise readable.

How recent should documentation be?

In order for a determination to be made regarding reasonable accommodations, documentation should verify the functional impact of the disability as it relates to the current test-taking situation. A diagnostic evaluation completed within the past year may be helpful as is information regarding the test taker's longer standing history of disability.

What documents should I submit?

In most cases, documentation should be based on a comprehensive diagnostic/clinical evaluation that adheres to professional standards as reflected in the guidelines outlined in this document. It is recommended that the diagnostic report/documentation include the following components:

- a listing (or narrative) of all sources of information directly obtained or reviewed by the clinician
- specific diagnosis or diagnoses
- description of current symptoms in the testing environment and across other settings (e.g., college, employment, social settings, etc.).
- information regarding psychotropic medications the test taker will likely use during test administration and the anticipated impact, including any "side effects" on the test taker in this test setting
- information regarding current treatment
- specific recommendations for accommodations with an accompanying rationale that directly links each recommended accommodation to a disability-related functional limitation; this rationale should be supported by objective data as well as clinical impressions as guided by professional standards
- a statement of differential diagnosis which indicates that the clinician has considered other diagnoses as well as co-morbidities (i.e., co-occurring disorders)

A. Historical Information, Diagnostic Interview, and/or Psychological Assessment

A diagnostic interview should include, but not be limited to, the following:

- history of specific presenting symptoms of the disability that the test taker has experienced and continues to experience (e.g., palpitations, sweaty palms, disoriented thinking, fatigue, reactivity to stress, etc.);
- onset of the disorder including frequency, intensity and duration of symptoms, including a narrative that distinguishes common psychological/emotional responses to a testing situation from the impact of disability-related functional limitations;
- developmental, historical and familial data (including any traumatic events, hospitalization, outpatient treatment, counseling/mental health services, conditions that run in test taker's family, etc.);
- medical and medication history, including the individual's current medication(s) and regimen adherence, side effects (if relevant), and positive and negative response(s) to medication. Many individuals benefit from prescribed medications and/or therapies. A positive response to medication in and of itself does not confirm a diagnosis, nor does the use of medication in and of itself either support or negate the need for accommodations;
- a description of functional limitations across contexts (e.g., academic testing, employment, social, etc.) with the understanding that a psychological disorder usually impacts an individual in a variety of settings in addition to the academic domain;
- if relevant to test-taking performance, a description of the expected progression or stability of the functional impact of the condition over time;
- if relevant to test-taking performance, information regarding type of treatment received, its effectiveness, and the duration and frequency of the therapeutic relationship; and
- if relevant, information regarding sleep hygiene and possible impact on functioning in a test-taking situation

B. Behavioral Observations

Behavioral observations, combined with the clinician's professional judgment and expertise, are considered in the formulation of a diagnostic impression. The clinician should clearly and specifically indicate, in detail, the test taker's relevant behaviors that impact their performance. Additionally, the clinician should indicate whether or not the behaviors clinically observed are consistent with the diagnosis and, if they are not, why not.

C. Documentation Should Include a Specific Diagnosis or Diagnoses

The documentation should include at least one specific diagnosis based on the latest edition of the DSM or the ICD, preferably listed in a specific diagnostic section of the report with the name of the diagnosis(es) and corresponding numerical code. Clinicians are also encouraged to provide meaningful contextual information (e.g., co-occurring medical diagnoses, current stressors and sociocultural factors, statements regarding general level of functioning, etc.) consistent with professional standards indicated in the DSM. Citing the specific objective measures used to help substantiate the diagnosis along with scores (i.e., standard scores and/or percentile ranks for all composite and subtest scores) is very helpful in documenting a need for reasonable accommodations.

D. Alternative Diagnoses or Explanations Should Be Ruled Out

Consistent with professional standards and to the extent possible, the clinician should investigate and rule out the possibility of other potential diagnoses that may alter the expression of a psychiatric disability. Neurological and/or medical conditions or substance abuse, as well as educational, linguistic, sensori-motor and cross-cultural factors, etc., may result in symptoms that mimic or exacerbate, and/or make it hard to determine the true nature of the purported psychiatric disability.

What if the submitted documentation is insufficient for current accommodation determination?

Due to the variable nature of the functional impact of psychiatric disabilities, it is important that a test taker submit documentation which clearly indicates the impact of their disability-related functional limitations upon the current testing situation. An individual's presentation and performance may vary over time even if the diagnosis remains unchanged. Reasonable accommodations are determined most effectively in the context of how the test-taker's functional limitations will impact their performance on the test they are currently applying to take. Accommodation requests are considered on an individualized basis which includes reviewing the totality of information provided.

In most instances a test taker's disability-related functional limitations in the current testing situation are most clearly determined via clinical evaluation conducted by an appropriate professional within 12 months of the requested accommodation(s). However, there is room for flexibility, depending on the following variables: a) the history of onset and/or duration of the disability; b) the nature and type of disability, including its stated or implied course; c) the severity of the disability; and d) other conditions at the time of last assessment, such as treatment status and stability of functioning.

After considering these variables, the clinician should additionally consider the following about the documentation:

1. Does the information submitted for review present a reasonably clear picture regarding the disability and the rationale for the requested accommodation(s)?

2. Is each recommended accommodation directly and explicitly linked to a disability-related functional limitation that is supported by data and/or specific clinical observations?

3. Is the information provided applicable to the current testing situation?

The answers to these three questions should help determine whether there is sufficient information provided regarding how the test taker's functional limitations relate to the current test they are applying to take and, if not, what additional specific information should be provided. In some situations a clinical update may be helpful. A clinical update is typically a letter from the treating clinician(s) specifically addressing current symptomatology or disability status, as well as the test taker's response to a previously documented recommendation for intervention. Sometimes more detailed information may be needed to clarify the test taker's functional limitations regarding the current testing situation; this is referred to as a documentation update.

A documentation update compiled by a qualified professional is a detailed narrative that includes a summary of the original disability documentation findings, as well as additional clinical data necessary to establish the candidate's need for the requested testing accommodation(s) in the current testing situation.

A documentation update should include:

- a listing of all primary sources of information reviewed by the clinician, restatement of the current diagnosis(es) including date(s) for all prior diagnoses and the basis upon which these diagnoses were determined. Reports of the test taker's lived experience are helpful in providing a more robust account of the test taker's subjective experience of the functional impact of their disability;
- verification of continuing weaknesses in those areas identified in prior documentation;
- discussion of functional limitations due to the disability as relevant to the current test taking situation including their frequency, intensity, duration and their impact on academic performance in general and on test taking in particular;
- behavioral observations gathered during the evaluation, including social reciprocity, affect, mood concentration, attention, mental stamina, executive functioning, personal hygiene, and language usage;
- types of accommodations approved and used in the past, consistency and circumstances of use (e.g., the type of test for which accommodations were most helpful), or an explanation of why no accommodations have been used prior to the current request but are needed now; and
- discussion of the reasonableness of the requested accommodation(s) for the current test the test taker is applying to take, along with the specific disability-related functional limitation(s) the linked accommodation(s) is meant to address.

Additional evaluation data for a psychiatric update may include achievement measures that illustrate the ongoing functional impact of the disability on academic performance. The updated evaluation need not include a full battery of tests but may include selected academic tests and subtests deemed appropriate to support requested accommodations. Additionally, documentation should provide an explanation of why certain subtests were selected for the update, interpretation of the reported scores, and a discussion of how error patterns in the candidate's performance reflect a substantial limitation to learning and/or test taking.

A rationale for each requested accommodation should be provided.

The clinician should describe the degree of functional impact of the diagnosed psychiatric disorder on a specific major life activity(ies) as well as the degree of impact on the individual. A direct link should be established between the requested accommodations and the disability-related functional limitations pertinent to the current testing situation. A diagnosis by itself does not automatically mean that an individual has functional limitations that impact a particular testing situation. Given that many individuals may benefit from extended time in testing situations, evaluators should provide an explicit disability-related rationale that supports the accommodation. With the exception of prior accommodation approval by another testing agency, a prior history of accommodations does not warrant the provision of accommodations. ETS recognizes that multiple factors may prevent a test taker from having had access to accommodations previously (e.g., lack of resources, lack of access to or availability of mental health care, cultural factors, etc.). If a test taker has no prior history of accommodations, it is helpful for the clinician and/or the test taker to provide a clear explanation of why accommodations were not sought or needed in the past and why they are currently being requested. Psychoeducational, neuropsychological, or behavioral assessments may provide important information regarding a test taker's disability-related functional limitations which warrant testing accommodations based on the potential for many psychiatric disorders to interfere with cognitive performance. A detailed discussion of the individual circumstances supporting the request for any accommodation based upon psychiatric disabilities may be very helpful.

Undergoing neuropsychological, psychological, or psychoeducational assessment may be helpful in establishing or reconfirming a diagnosis and documenting its impact on an individual's academic functioning as it relates to the current testing situation. Obtaining standardized measures of performance on a range of academically relevant tasks can guide the accommodation review process by objectively illustrating the test taker's disability-related functional limitations and identifying the type and extent of formal assistance that is likely to be effective. Beyond the issue of documenting the test taker's functional limitations and need for accommodations, such assessment can also provide insights into one's profile of cognitive strengths and vulnerabilities and help test takers generally compensate and advocate for themselves. Many applicants with psychiatric disabilities do not need to undergo such psychometric assessments or achievement testing in order to qualify for testing accommodations. ETS determines the sufficiency of submitted documentation on a case-by-case basis and bases accommodation decisions on the totality of information provided with a commitment to the least burdensome process for each test taker.

Multiple Diagnoses

Multiple diagnoses may require a variety of accommodations beyond those typically associated with the functional impact of a single diagnosis. When accommodations are requested by a test taker with multiple diagnoses (e.g., a psychological disability with an accompanying learning disability), it may be sufficient in some instances to provide documentation for either disability category (i.e., psychiatric disorder or learning disability). However, in other instances, documentation for both disability categories will be most helpful in order to provide a sufficient understanding of the test taker's functional limitations in relation to the current testing situation. Clinicians may find it helpful to consult ETS's policies and guidelines for documentation. If the accommodations requested are not supported by the current documentation and multiple diagnoses are suspected, the clinician should recommend/refer the individual to another appropriate qualified professional for additional assesment.

Additional Sources of Information

Other sources of documentation are often helpful to corroborate symptoms of a disorder and support the need for the requested accommodation(s) (i.e., prior evaluation reports, information from other treating professionals, medical records, information from third-party informants such as family members, instructors, school records such as an IEP, Section 504 Plan, Standards of Performance [SOP], transition documentation, etc.). Relevant information from these sources can be summarized by the clinician in the current disability documentation and/or included as an attachment by the applicant. Such documents may provide useful supplemental information about a test taker's educational history, history of eligibility for services, history of limitations to academic achievement, and history of accommodation use.

Other supplemental forms of documentation may include evidence of a reduced course load or the number of incompletes or dropped courses, a copy of an accommodation letter to faculty and/or letter from a content area teacher. A detailed letter from a college disability services provider, a vocational rehabilitation counselor, or a human resources professional describing current limitations and use of accommodations may also be helpful to supplement documentation.

A test taker's description of their lived experience frequently provides a more robust illustration of the disability-related functional limitations they encounter generally as well as in high stakes testing situations. ETS welcomes test takers to submit a personal statement which describes in their own words their past and present academic difficulties as well as coping strategies they use and find helpful. The applicant's personal statement should highlight the most relevant information from other forms of documentation. A one-page personal statement is typically sufficient and may include information such as the date of the initial diagnosis, accommodations history in a variety of settings, a statement explaining the need for accommodations that are presently requested, and any additional information that the test taker thinks it might be important for ETS to know for the purpose of accommodation determination.

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