MAT
MILLER ANALOGIES TEST®

# Documentation Needed to Request Accommodations

When requesting special accommodations, make sure to turn over all necessary documentation to the CTC where you wish to take the MAT. You must have the following:

- ☐ **A completed Accommodations Request Form**
- ☐ **A signed HIPAA statement**
- ☐ **A current letter (not more than three years old) from a licensed professional with training that is applicable to diagnosing the disability**

The letter must appear on the licensed professional's official letterhead and include:

- The licensed professional's title, address, and telephone number
- A description of the nature of the functional limitation as it applies to taking a multiple-choice standardized test
- The specific accommodations the candidate will need for testing

The authority providing this letter may also include test results, a signed school Individual Education Plan (diagnosis and plan), or other official documentation that identifies the candidate's disability and the accommodation he or she requires.

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# Accommodations Request Form

Name_____ Date:_____
Last First M.I.

Address: _____

_____

_____

MAT Controlled Testing Center: _____

MAT Administrator's Name: _____

Daytime Telephone Number_____Email: _____

Description of Disability: _____

_____

_____

Accommodations Requested (Check all that apply):

- ☐ Audio CD Exam
- ☐ Braille Exam
- ☐ Large Print Exam
- ☐ Additional Breaks
- ☐ Additional Time
  - ☐ Time and a Half
  - ☐ Double Time
- ☐ Reader
- ☐ Scribe/Writer
- ☐ Sign Language Interpreter
  - ☐ American Sign Language
  - ☐ Cued Speech
  - ☐ Other _____
- ☐ Separate Testing Room
- ☐ Accessible Facilities
- ☐ Additional Time (Please explain): _____

  _____
- ☐ Other Equipment or Accommodation (please explain): _____

  _____

  _____

Accommodations previously provided to you—list accommodations received and purpose (e.g., "Sign language interpreter for MAT examination"):_____

_____

_____

If you have any questions about your accommodations, please contact PSE Customer Relations at 1-800-622-3231.

# HIPAA CONSENT FORM

AUTHORIZATION (CONSENT) TO PERMIT THE USE AND DISCLOSURE OF IDENTIFIABLE MEDICAL INFORMATION (PROTECTED HEALTH INFORMATION) FOR ACCOMMODATION PURPOSES

Candidate Name:

Accommodation Requested:

The Health Insurance Portability and Accountability Act (HIPAA) provides safeguards to protect your privacy. Implementation of HIPAA requirements officially began on April 14, 2003.

What this is all about: Specifically, there are rules and restrictions on who may see or be notified of your Protected Health Information (PHI). These restrictions do not include the normal interchange of information necessary to provide you testing services. HIPAA provides certain rights and protections to you as the patient. We balance these needs with our goal of providing you with quality professional service and care. Additional information is available from the U.S. Department of Health and Human Services. www.hhs.gov

We have adopted the following policies:

1. You agree that your diagnostic physician can provide NCS Pearson, Inc. ("Pearson") with any necessary medical information in support of your requested accommodation. By signing below, you grant us consent and permission to request the information from your physician for the sole purpose to make a determination regarding your requested accommodation for your test administration.
2. Candidate information will be kept confidential except as is necessary to determine the accommodation request for the test administration. This specifically includes the sharing of information with other healthcare providers or laboratories as is necessary and appropriate for the determination of your accommodation. Your information may be retained only as it applies to your administration of the test. Your records will not be available to persons other than Pearson staff and administrators. You agree to the normal procedures utilized by Pearson for the purpose of determining and providing your request for accommodation.
3. It is the policy of Pearson to notify you of your request by telephone, e-mail, U.S mail, or by any means convenient for the practice and/or as requested by you. We may send you other communications informing you of changes to your accommodation request and new technology that you might find valuable or informative.

4. The practice utilizes a number of vendors in the conduct of business. These vendors may have access to your information but must agree to abide by the confidentiality rules of HIPAA.
5. You understand and agree to inspections of the office and review of documents which may include Pearson by government agencies or colleges in normal performance of their duties.
6. You agree to bring any concerns or complaints regarding privacy to the attention of the Pearson.
7. Your confidential information will not be used for the purposes of marketing or advertising of products, goods or services.
8. We agree to provide candidates with access to their records in accordance with state and federal laws.
9. We may change, add, delete or modify any of these provisions to better serve the needs of the both the practice and the patient.
10. You have the right to request restrictions in the use of your protected health information. However, we are not obligated to alter internal policies to conform to your request.

I, _____date_____ do hereby consent and acknowledge my agreement to the terms set forth above in the HIPAA INFORMATION FORM and any subsequent changes.

_____

Signature