



Documentation Needed to Request Accommodations

When requesting special accommodations, make sure to submit all necessary documentation to Pearson by email to MATScoring.Services@Pearson.com.

Required Documentation:

- A completed Accommodations Request Form (See the [MAT Testing Centers PDF to contact site and obtain info for completing the MAT Accommodations Request form](#))
- A completed HIPAA consent form, including signature
- 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 all of the following:

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

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(s) required.

All documentation must be submitted together. If any documentation is missing, it must be submitted within 45 days or the accommodations review process will expire.

If you have any questions about your accommodations, please contact MAT Customer Relations at MATScoring.Services@Pearson.com or 1-800-622-3231 Monday through Friday, 9:00 a.m. to 4:00 p.m. Central Time (subject to change).



Accommodations Request Form

Candidate Information:

Name: _____ Today's Date: ____/____/____
Last First M.I. Month/Day/Year

Daytime Telephone Number: _(____)_____ Proposed Test Date: ____/____/____
Month/Day/Year

Email address: _____

Description of Disability: _____

Accommodations Requested (Check all that apply):

- | | | |
|---|---|--|
| <input type="checkbox"/> Accessible Facilities | <input type="checkbox"/> Large Print Exam | <input type="checkbox"/> Sign Language Interpreter |
| <input type="checkbox"/> Additional Time | <input type="checkbox"/> Reader | <input type="checkbox"/> American Sign Language |
| <input type="checkbox"/> Time and a Half (x1.5) | <input type="checkbox"/> Scribe/Writer | <input type="checkbox"/> Cued Speech |
| <input type="checkbox"/> Double Time (x2) | | <input type="checkbox"/> Hand Held Magnifier |
| <input type="checkbox"/> Separate Testing Room | | |
| <input type="checkbox"/> Other Equipment or Accommodation (Please explain): _____ | | |

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

MAT Controlled Testing Center (CTC) Information

(Location where candidate wants to take the exam)

To avoid processing delays, this section must be completed by the candidate. See the [MAT Testing Centers](#) PDF for CTC contact information.

- I have confirmed with the test site that the location does have the needed resources to meet my accommodations request

CTC Name: _____ CTC Number: 0800 □□□□

Administrator's Name: _____

Telephone Number: (____) _____

Email address: _____

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. 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 the Candidate agree and understand that your diagnostician (whether a physician or other provider) can provide NCS Pearson, Inc. ("Pearson") with any necessary medical information to support and/or verify your requested accommodation. By signing below, you grant Pearson your consent and permission to request the information from your diagnostician for the sole purpose of making 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. 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 necessary to determine your accommodation. 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. You understand and agree to reasonable inspections of Pearson's records and review of documents (which may include your Consent Form and supporting documentation) which may be made by government agencies or colleges in the normal performance of their duties.
5. You agree to bring any concerns or complaints regarding any privacy matter to the attention of Pearson.

6. Your confidential information will not be used for the purposes of marketing or advertising of products, goods or services.
7. Pearson agrees to provide Candidates with access to their records in accordance with applicable state and federal laws.
8. Pearson may change, add, delete or modify any of these provisions.
9. 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 CONSENT FORM and any subsequent changes.

Signature