



## **Housing Accommodation Request for Students with Severe Medical Condition or Disabilities**

### **Directions:**

#### **Students:**

- Complete Part I
- Sign the Consent for Release of Information on p. 2
- Provide entire form to your disability evaluator or physician.
- If you are requesting housing accommodations only for asthma or allergies, submission of Part I and Part II of the Request will make your application complete.
- If you are requesting housing accommodations for disabilities including, but not limited to, Autism Spectrum Disorder (ASD), Chronic Medical/Health disabilities, or Psychological/Psychiatric disabilities, you must ask your disability evaluator or physician to complete the appropriate disability documentation form(s) in order to make your application complete. These forms are located at the Office of Accessibility Services (OAS) and on the OAS portal page on the campus website.

**REFER TO THE PAGES ATTACHED BEHIND THIS FORM FOR DOCUMENTATION REQUIREMENTS.**

#### **Disability Evaluators and Physicians:**

- **Complete Part II**
- **Return the entire Housing Accommodation Request and the documentation that substantiates the medical condition or disability to the Office of Accessibility Services by mail.**
- **ADDITIONAL INFORMATION:**
  - *The Special Accommodations Team (SAT), comprised of several departments - reviews ALL requests.*
  - *SAT decisions are based upon the information provided by you and your disability evaluator or physician. Detailed information must be provided by a qualified individual who is not related to the student. Incomplete forms will not be reviewed or considered. Appeals are considered only when new information is provided. This process may change at any time.*
  - *The SAT reserves the right to ask for additional documentation and/or meet with the student, if such information is needed to make an accommodation decision.*

Student's Name: \_\_\_\_\_

- *Accommodation decisions are communicated to the student via email and housing details are provided by the Office of Residence Life.*
- ***All requests are due before February 1 for returning students and before June 1st for new students.***

**Part I: Student to complete the following:**

Name (please print clearly): \_\_\_\_\_

ID#: \_\_\_\_\_

Home Address: \_\_\_\_\_

Student Cellular #: \_\_\_\_\_

Student Home Phone #: \_\_\_\_\_

Caldwell University Email: \_\_\_\_\_

Status/Campus:     Incoming Freshman     Transfer     Returning

Accommodation Request is for:     Fall     Spring     Sum1     Sum2    Year: \_\_\_\_\_

1. State the condition for which you are requesting a housing accommodation:  
\_\_\_\_\_  
\_\_\_\_\_

2. What housing accommodation are you requesting?  
\_\_\_\_\_  
\_\_\_\_\_

3. Have you had this accommodation at Caldwell University in the past? \_\_\_\_\_

4. Please describe how this accommodation will reduce the impact of your condition in the residence halls.  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Student's Name: \_\_\_\_\_

5. Please add any other information you feel is important for us to consider in reviewing your request.

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

**Consent for Release of Information (to be completed by student):**

I authorize \_\_\_\_\_ (physician or evaluator's name) to disclose the information requested by this form to the Office of Accessibility Services and Student Health Center of Caldwell University for the purpose of evaluating my request for housing accommodations. I also allow both parties to discuss any information related to my housing accommodation request.

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

**Physician - REFER TO THE PAGES ATTACHED BEHIND THIS FORM FOR DOCUMENTATION REQUIREMENTS.**

**Part II: Physician or Disability Evaluator to complete the following:**

**PROFESSIONAL EVALUATION OF DISABILITY**

Accommodations are available to students identified as having a disability or **severe** medical problem. A disability is defined under the Americans with Disabilities Act as "a physical or mental impairment that substantially limits one or more major life activities."

Examples of major life activities are: Major bodily functions, seeing, hearing, eating, sleeping, walking, standing, lifting, bending, speaking, breathing, learning, reading, concentrating, thinking, communicating, working, performing manual tasks, and caring for oneself.

**Air conditioning requests should only be made for extreme medical conditions. Note that allergies rarely meet this criteria. A request for air conditioning must include proper documentation. Refer to the document requirement pages for clarification.**

1. Based on this definition does the individual have a disability? \_\_\_\_\_ No \_\_\_ Yes

- o **If YES please complete the remainder of the form.**

- If NO, accommodations will be considered not be medically necessary.

Date of original diagnosis: \_\_\_\_\_ Date of most recent evaluation: \_\_\_\_\_

Is the student currently under your care? \_\_\_\_\_ Yes \_\_\_\_\_ No

2. State the student's disability diagnosis, including diagnostic code.

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3. Check any areas of functioning impacted by the disability. Explain the limitation. Circle the degree of limitation.

**Area of Functioning (check)**                      **Limitation on Functioning (explain)**                      **Degree of limitation (circle)**

<input type="checkbox"/> Hearing		Mild   Moderate   Severe
<input type="checkbox"/> Vision		Mild   Moderate   Severe
<input type="checkbox"/> Speech		Mild   Moderate   Severe
<input type="checkbox"/> Manual Dexterity		Mild   Moderate   Severe
<input type="checkbox"/> Ambulation		Mild   Moderate   Severe
<input type="checkbox"/> Motor Coordination		Mild   Moderate   Severe
<input type="checkbox"/> Activities of Daily Living		Mild   Moderate   Severe
<input type="checkbox"/> Endurance		Mild   Moderate   Severe
<input type="checkbox"/> Respiratory		Mild   Moderate   Severe
<input type="checkbox"/> Climatic/Environment		Mild   Moderate   Severe
<input type="checkbox"/> Cognitive Skill		Mild   Moderate   Severe
<input type="checkbox"/> Sleep		Mild   Moderate   Severe
<input type="checkbox"/> Social Interaction		Mild   Moderate   Severe

Student's Name: \_\_\_\_\_

<input type="checkbox"/> Eating		Mild	Moderate	Severe
<input type="checkbox"/> Other		Mild	Moderate	Severe

4. Describe the student's **functional limitations** or **behavioral manifestations** that you would foresee in a college residential hall setting. **What do you foresee as the impact?**

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5. What is the expected duration, stability, or progression of the disability?

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6. Please describe **current treatments, prosthetic devices, and or medications prescribed.**

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7. Is the disability mediated or controlled by medications, other treatments, or external prosthetics?  
\_\_\_\_\_ Yes \_\_\_\_\_ No. Please explain: \_\_\_\_\_

8. Please state **specific recommendations** for reasonable housing accommodations to address the **functional limitations of the disability noted above.**

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9. What housing accommodations do you consider to be **preferred** but **not medically necessary?**

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If the **disability** is **asthma or allergies**, please provide additional information **specific to the student's health condition** using the sections below.

**Air conditioning requests should only be made for extreme medical conditions. Note that allergies rarely meet this criteria.**

**ASTHMA**

1. Current diagnosis (select one):

Student's Name: \_\_\_\_\_

- Exercise induced Asthma
- Intermittent Asthma
- Persistent Asthma
- Other (please define): \_\_\_\_\_

2. Current Asthma Medications (please note medication(s) name and dosage):

- Short-acting Beta Agonists \_\_\_\_\_
- Long-Acting Beta Agonists \_\_\_\_\_
- Inhaled corticosteroids \_\_\_\_\_
- Other \_\_\_\_\_

3. Please check any of the following which are true for your patient (dates required):

- History of severe asthma exacerbations requiring emergency care (most recent date) \_\_\_\_\_
- Prior intubation for asthma \_\_\_\_\_
- Hospital admission for asthma (most recent hospitalization date) \_\_\_\_\_
- Prior office visits for asthma exacerbation (3 most recent visit dates) \_\_\_\_\_
- Prior use of IM or oral corticosteroids for asthma (most recent date prescribed) : \_\_\_\_\_
- Currently requires more than 2 canisters of short-acting beta agonist per month: Yes or No

4. Are symptoms: \_\_continuous \_\_intermittent \_\_ seasonal \_\_other (please explain)

5. Severity of symptoms: \_\_mild \_\_moderate \_\_\_ significant \_\_ other (please explain below)

**ALLERGIES**

1. Current Diagnosis:

- Allergic Rhinitis (circle one): *Seasonal Perennial*
- Allergic conjunctivitis
- Other (diagnosis)

2. Current Allergy medications (including medication name and frequency of daily use):

- Antihistamines \_\_\_\_\_
- Steroid nasal inhaler \_\_\_\_\_
- Other \_\_\_\_\_

3. Please check any of the following which are true for your patient (dates required):

- Allergies documented by skin testing or other diagnostic testing (most recent date): \_\_\_\_\_
- Prior of current immunotherapy (allergy shots): \_\_\_\_\_
- Other \_\_\_\_\_

4. Are symptoms: \_\_continuous \_\_intermittent \_\_seasonal \_\_other (please explain):

5. Severity of symptoms: \_\_mild \_\_moderate \_\_\_significant \_\_other (please explain)

**THIS SECTION MUST BE COMPLETE FOR FORM TO BE VALID**

Evaluator/ Dr. Name: \_\_\_\_\_

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

Office Address: \_\_\_\_\_

Student's Name: \_\_\_\_\_

Phone: \_\_\_\_\_

How long have you treated this patient? \_\_\_\_\_

Date of most recent office visit? \_\_\_\_\_

May we contact you if we have questions about this student's accommodation request?

\_\_\_\_\_ Yes      \_\_\_\_\_ No

If no, please explain circumstances:

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

Date: \_\_\_\_\_

**PROVIDER:**

- ✓ Please include a copy of your letterhead
- OR
- ✓ Use your office stamp on this document
- ✓ OR attach a script

**PLEASE MAIL OR FAX THE COMPLETED FORM AND DOCUMENTATION TO:** Caldwell University, Office of Accessibility Services, 120 Bloomfield Avenue, Caldwell, N.J. 07006. FAX: 973-618-8433



**CALDWELL**  
UNIVERSITY.

Office of Accessibility Services  
120 Bloomfield Avenue, Caldwell, NJ 07006  
PHONE 973-618-3645  
FAX: 973-618-3488

## **Caldwell University Documentation Requirements**

Students seeking disability services through the Office of Disability Services (ODS) on the basis of diagnosis of a neurological impairment, psychiatric disorder, or medical impairment are required to submit documentation to verify eligibility under Section 504 of the Rehabilitation Act of 1973, and the Americans with Disabilities Act of 1990 as amended.

Secondary schools and post-secondary institutions are governed under different laws with regard to providing services to students with disabilities. A prior history of accommodation does not warrant the provision of a similar accommodation at the post-secondary level. A student's individualized education plan (IEP) or a 504

Plan is seldom sufficient documentation to establish the rationale for academic adjustments, auxiliary aids or services in the post-secondary setting. However, an IEP or 504 Plan may accompany primary documentation of a disability.

### **Neurological Impairment**

Documentation of neurological impairments must include a report from a neurologist or other qualified medical doctor. It is important to understand that a diagnosis of a neurological condition in and of itself does not substantiate a disability. In other words, information sufficient to render a diagnosis might not be adequate to determine that an individual is substantially impaired in a major life activity. Current (within one year) and comprehensive documentation must be provided in order for a student to be eligible for support services and be considered protected under the law.

The following guidelines (see below) are provided in the interest of assuring that documentation is appropriate to verify eligibility and support requests for reasonable accommodations, academic adjustments, and/or services in the post-secondary setting.

### **Psychiatric Disorders**

Documentation of psychiatric disorders must include a report from a psychiatrist or qualified clinical psychologist. Psychiatric Disorders Professionals conducting assessments rendering a diagnoses of psychiatric disorders must be trained in differential diagnosis and the full range of psychiatric conditions. The following professionals are considered qualified to evaluate and diagnose psychiatric disorders provided they have comprehensive training in differential diagnosis and direct experience with adolescent and/or adult populations: licensed clinical psychologists and psychiatrists. Use of diagnostic terminology indicating a psychiatric disorder by someone without training and experience in these fields is not acceptable. The following guidelines (see below) are provided in the interest of assuring that documentation is appropriate to verify eligibility and support requests for reasonable accommodations, academic adjustments, and/or services in the post-secondary setting.

### **Medical Impairment**

Documentation of medical impairments must include a report from a healthcare professional that is qualified to make the diagnosis in question. The report must reflect the current limitations of the impairment (documentation for mobility impairments may require periodic updates, especially if changes occur in the student's functioning). In addition, documentation of mobility impairments must fully explain the following aspects of the student's impairment (if applicable). The following guidelines (see below) are provided in the interest of assuring that documentation is appropriate to verify eligibility and support requests for reasonable accommodations, academic adjustments, and/or services in the post-secondary setting.



**Caldwell University DOCUMENTATION GUIDELINES - Requirements**

All diagnostic reports must include the names, titles, licensure and professional credentials of the evaluators and include the signature of the professionals and the dates of testing/assessments. The report must be typed and submitted on professional letterhead complete with address and telephone number. Specific reporting format is left to the professional; however, the required components must be clearly presented and easily discernable. Handwritten diagnostic reports are not acceptable.

Documentation of neurological impairments must include a report from a neurologist or other qualified medical doctor. Documentation of psychiatric disorders must include a report from a psychiatrist or qualified clinical psychologist. Documentation of medical impairments must include a report from a healthcare professional that is qualified to make the diagnosis in question.

Information that is more than a year old may be considered as out of date depending on the student's age, student's age at time of assessment and the nature of the diagnosis. The report must reflect the current functional limitations of the impairment (documentation for neurological impairments may require periodic updates, especially if changes occur in the student's functioning).

- Diagnosis
- Duration (chronic, episodic, or short-term) of the impairment
- History of the impairment and the symptoms related to the impairment
- Severity (mild, moderate, or severe) and an explanation of the severity
- Dates and frequency of contacts with the student/patient
- Explanation of how the impairment limits the student's functioning for the college environment
- Detailed explanation of how the impairment limits the student's functioning for the college environment
- List of the student's relevant current medication (dosage, frequency, and adverse side effects) and an explanation of the extent medication mitigates the symptoms of the disorder
- Specific recommendations regarding academic adjustments, housing accommodations, auxiliary aids, and/or services are warranted based upon the student's functional limitations
- Indication as to the reason the stated academic adjustments, housing, accommodations, auxiliary aids, and/or services are necessary if the current treatments are successful
- Information regarding situations that may exacerbate the student's impairment

**Documentation Retention**

All submitted materials will be held in the disability services office as educational records under The Family Educational Rights Privacy Act (FERPA). Students have a right to review their educational record. However, students are encouraged to retain their own copies of disability documentation for future use, as the college is not obligated to produce copies for students. Under current New Jersey record retention requirements, disability documentation is mandated to be held for only two years after a student has stopped attending the college.

