DAKOTA STATE
OFFICE OF DISABILITY SERVICES

REQUEST FOR HOUSING EXEMPTION/ACCOMMODATION

To evaluate a student's needs for special housing assignment requests, the University requires specific diagnostic information from a licensed health care provider. This health provider must be familiar with the history and functional limitations of the student's physical or psychological condition(s). **The student must complete pages two and three of this packet (Student Information and the Authorization for Release or Exchange of Information sections). To facilitate this process, the student or parent/legal guardian, if the student is under the age of 18, is required to complete and sign the Authorization for Release or Exchange of Information**. This signature allows the health provider to provide information to the University and allows the appropriate and qualified Dakota State University staff members, permission to discuss the student's condition or resulting determination with the health provider filling out this form. The student then provides the form to the student's health provider for the health provider to complete the Diagnostic information section on pages 5-8 and return the complete packet to:

Dakota State University
Disability Services
820 N Washington Avenue
Madison, SD 57042

FAX: (605) 256-5121

DSU Housing Roommate Philosophy:

The Office of Housing and Residence Life believes that the experiences shared through being a roommate are valuable and essential to a student's college education and development. Essential life skills such as open, honest and effective communication, negotiation, cooperation, tolerance, compromise, respect, etc. are all experience-based opportunities for growth created in a double occupancy housing environment.

Therefore, University Housing will place first year students in a double occupancy room unless a student meets the accommodation criteria and is approved to occupy a single room. The opportunity for upper-class students to be assigned a non-exemption based private single occupancy room is dependent on space availability. Upper class students will be placed in a single occupancy room if they meet criteria and are approved to occupy a single room.

Note on Single Rooms:

A request for a single room will be reviewed; however, **the provision of a single-room as an accommodation is not common**. A single room does not guarantee privacy or a quiet environment. Students who need to study in a quiet environment can utilize quiet spaces on campus such as rooms in the library. A single room also does not guarantee an allergen-free environment. A single room will not prevent a student from having to interact and negotiate living arrangements with other students, such as alone time, sleep patterns and study schedules.

Student Information

Student completes the section below & the Authorization for Release or Exchange of Information section on page 3. (*Please Print Legibly)*

Student Name: _____
(Last) (First) (Middle Initial)

Student ID#: _____ E-Mail: _____

Birth date: _____ Gender identification: ☐ Male ☐ Female

Home Phone: _____ Cell Phone: _____

Reason for Requesting Consideration:_____

_____

_____

_____

_____

I am requesting consideration for: (Check the appropriate box below.)

- ☐ Placement in an on-campus single occupancy room.
- ☐ Authorization to live off campus.
- ☐ Placement in a specific location. Examples: first floor location; close to a restroom

Submission Deadlines: • July 14h for the fall semester • December 3rd for spring semester

Authorization for Release or Exchange of Information

Name of Health Care Provider:

Information to be released or exchanged:

- ☐ History & Physical Exam
- ☐ Discharge Summary
- ☐ Psychiatric Evaluation
- ☐ Psychological Test Results
- ☐ Chemical Recovery History
- ☐ Dates of Hospitalization
- ☐ Court/Agency Documents
- ☐ Treatment Plans
- ☐ Progress Notes
- ☐ Therapist Orders
- ☐ Diagnosis
- ☐ Crisis Intervention Reports
- ☐ Medical Records
- ☐ Family Systems Evaluation
- ☐ Educational Records & Progress
- ☐ Educational Test & Reports
- ☐ Psychosocial Report
- ☐ Other:

<u>For Students Under the Age of 18 only:</u>

As parent or legal guardian of , I authorize the release or exchange of information.

I have the right to revoke the authorization at any time by presenting a written revocation to the Residence Life Department. I understand the revocation will not apply to information already released in response to the authorization. Unless otherwise revoked, this authorization shall be in effect for one year from this date, for records generated because of service occurring on or prior to this date.

I understand authorizing the disclosure of health information is voluntary. I can refuse to sign this authorization, I understand I may inspect or obtain copies of the information to be used or disclosed. I understand any disclosure of information carries with it the potential for unauthorized redisclosure and the information may not be protected by federal confidentiality rules. If I have any questions about disclosure I can contact the Department of Residence Life at 605-256-5146.

Student signature (if 18 years or older) OR parent/guardian signature (if student is under the age of 18) **Date**

Dear Health Care Provider:

One of your patients has requested a medical accommodation at Dakota State University. The Disability Services Coordinator will review of the information you provide to determine if the requested accommodation will be approved or not. The documentation provided regarding the diagnosed disability must demonstrate a disability covered under Section 504 of Rehabilitation Act of 1973 and Title II of the Americans with Disabilities Act (ADA) of 1990. **The ADA defines a disability as a physical or mental impairment that substantially limits one or more major life activities**. In addition, for a student to be considered eligible to receive an accommodation, the documentation must show functional limitations that impact the individual in a residential setting. Current and comprehensive documentation is required to determine appropriate services and accommodations. The information below outlines what is needed to evaluate eligibility for medical accommodations.

Attached is the Dakota State University Request for Housing Exemption/Accommodation form. **The student must complete the Student Information and the Authorization for Release or Exchange of Information sections and provide the completed sections to the student's health provider. The health provider must complete the Diagnostic Information section and return the completed form in its entirety to the Office of Residence Life, Dakota State University.** Disability forms cannot be completed by a relative or friend of the student or his/her family requesting the accommodation.

- **All parts of the form must be completed as thoroughly as possible.** Inadequate information, incomplete answers and/or illegible handwriting will delay the eligibility review process by necessitating follow up contact for clarification. **The health care provider should attach any reports which provide additional related information.**
- **After completing and signing this form, include the Health Care Provider Information Section on the last page. Please fax to 605-256-5854 or mail to the Disability Services Office, 820 N. Washington Ave., Madison, SD 57042.** The information you provide will not become part of the student's educational records, but will be kept in the student's medical file, where it will be held strictly confidential. This form may be released to the student at his/her request. In addition to the requested information, please attach any other information that would be relevant to assist us in making a determination for a medical accommodation.
- When the documentation is received by the Residence Life Office, the student will receive an email notification.
- Once completed documentation is received, the Disability Services Coordinator will review the request. After a decision is determined, a letter or email will be sent to the student outlining what non-academic accommodation(s) (if any) will be made. **Documentation for a request must be received by the Disability Services Office by the established deadline**.

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If you have any questions regarding this form, please call the Disability Services Office at 605-256-5121. Thank you for your assistance.

DIAGNOSTIC INFORMATION

(To be completed by the health provider; *please print legibly*):

1. Does your patient meet the disability criteria defined as:

   - Individual with a physical or mental impairment that **substantially limits one or more major life activities**
   - Individual with a record of such impairment
   - Individual who is regarded as having such an impairment

   ☐Yes ☐NO

Examples of major life activities: (includes those activities that are important to daily life):

☐ Performing manual tasks ☐ caring for oneself ☐ learning ☐ walking
☐ Hearing ☐ seeing ☐ breathing ☐ speaking
☐ Operation of major bodily activities

2. What is the diagnosis, date of initial diagnosis, and last contact with the student for this diagnosis?

   Diagnosis: _____

   Date of initial diagnosis: _____

   Date of last contact with student for this diagnosis: _____

3. Is the student currently under your care? ☐Yes ☐NO If yes, how often do you see this student?

   _____

4. What is the expected duration of this disability?

   _____

   _____

   _____

List current medication(s), dosages, impact and adverse side effects. Is the student compliant with the medication(s)?
☐Yes ☐No

_____

_____

5. Describe the medical treatment plan; please indicate how the treatment might affect the student's ability to live in residential housing?

_____

_____

_____

_____

6. What is the severity of the disorder? ☐Mild ☐Moderate ☐Severe

7. Major Life Activities Assessment
   Please indicate the number that best reflects the degree that the following life activities are affected:

Life Activity	0-None	1-3 Mild	4-7 Moderate	8-10 Severe
Caring for self				
Talking				
Hearing				
Walking				
Breathing				
Standing				
Reaching				
Lifting				
Sitting				
Seeing				
Sleeping				
Eating				
Toileting				
Performing manual tasks				
Other:				
Other:				
Other:				

8. Describe the functional limitations that are a result of the medical condition, and list recommendations and rationale for the accommodations that are being requested:

   Functional Limitation: _____

   _____

   _____

   _____

   Recommendation for Accommodation: _____

   _____

9. Describe any situations or environmental conditions that might lead to an exacerbation of the condition.

   _____

   _____

   _____

10. Describe the steps that the student has taken (or will take) to personally address his/her needs: (Example of steps to help control asthma: using portable air purification system; using dust mite proof pillow & mattress casings.)

    _____

    _____

    _____

HEALTH CARE PROVIDER INFORMATION

(*Please fill in completely, sign & date*)

Provider Name (Print): _____

Title: _____

License/Certification Number: _____

Address:

_____

_____

_____

Phone Number: _____

Provider Signature: _____

Date: _____