HOUSING REQUESTS DUE TO MEDICAL, PSYCHOLOGICAL, OR DISABILITY REASONS

In order to evaluate how we can best meet your needs, we require specific information from both you and your examiner. In order to receive housing accommodations, you must complete this form. You must also fill out and sign the Authorization to Receive Health Care Information below. This gives us permission to speak with your examiner if we have questions regarding their recommendation for accommodations. Your healthcare provider must complete the rest of this form, sign it, and return the completed packet to the above address.

Policies and Procedures

The learning environment and residential living are central to the University of Delaware student experience. Residence Life & Housing refers or forwards all medical, psychological or disability related requests for housing accommodations to the Disability Support Services (DSS) Office. The information is kept confidential and is used to evaluate requests while evaluating each individual situation. To aid this process, requests should include:

- This completed Housing Documentation Form
- Any other relevant information you feel is necessary

In addition to the basic documentation about a medical condition, further recommendations from the Professional are welcome and will be given consideration in evaluating a request. Documentation usually must be updated annually unless the condition is such that it does not change. Please contact the DSS Office if you feel this applies to your situation.

Students requesting housing accommodations through the DSS Office must do so in addition to following all regular Residence Life & Housing procedures by the established deadlines.

Please note: If you are requesting to be released from your UD housing contract or housing requirement due to a medical, psychological, or disability reason, please visit the Residence Life and Housing website for additional information.
This form is not applicable - do not complete.

Factors we consider when evaluating requests for housing accommodations:

- Is the impact of the condition life-threatening if the request is not met?
- Is the request an integral component of a treatment plan prescribed by a medical professional for the condition in question?
- Was the request made with the initial housing request by the deadline?
• Was the request made as soon as possible after identifying the need (if known by the housing deadlines)?
• Is space available to meet the student’s need?
• Can space be adapted without creating a safety hazard?
• Are there other effective means that would achieve similar benefits as the requested accommodation?
• How does meeting the need impact housing commitments for other students?

**Note:** Housing Accommodations are provided on a case-by-case basis due to documented disabilities and medical conditions. To qualify as an American with Disabilities Act (ADA) covered disability, the student must have a current condition that substantially limits a major life activity, and the accommodation must be necessary and reasonable. A diagnosis, in and of itself, does not automatically qualify for accommodations. To receive special housing consideration for medical conditions is not covered by the ADA, this form must be completed, but accommodations are not guaranteed.

**STUDENT SECTION (Please print or type)**

Housing Application Academic Year: ______________ Date: _____________________________

Student ID: ____________________________

Student Name (last, first, middle): _________________________________________________

Date of Birth: ___________ Male: Female:

New Freshman Returning Student Transfer Student

Current Campus Address (if applicable): _____________________________________________

Home Address: __________________________________________________________________

Phone Number: __________________________

Email Address: __________________________

**AUTHORIZATION TO RECEIVE INFORMATION**

I authorize the University of Delaware, DSS Office, to receive information from the professional who fills out the Housing Needs Documentation Form, and for him/her to discuss my condition(s) with the DSS Office if necessary.

Student Signature: __________________________ Date: ____________________________
**MEDICAL PROFESSIONAL SECTION**

*This section is to be completed by the student’s healthcare provider.*

Student’s Name: _______________________________________________________________

Current medical condition/diagnosis:

____________________________________________________________________________

____________________________________________________________________________

Please select one:   Mild   Moderate   Severe

Expected duration of the condition: Temporary   Permanent   Stable   Progressive

Describe the symptoms related to the medical condition that cause significant impairment to a major life activity (i.e. walking, breathing, sleeping, seeing, hearing, learning, socializing). Please relate it to accommodations requested.

____________________________________________________________________________

____________________________________________________________________________

____________________________________________________________________________

____________________________________________________________________________

List the current medication(s) the student has been prescribed and any adverse side effects.

____________________________________________________________________________

____________________________________________________________________________

____________________________________________________________________________

____________________________________________________________________________

Are there significant limitations to the student’s functioning directly related to the prescribed medications? Yes   No
If yes, please describe.

____________________________________________________________________________

____________________________________________________________________________

____________________________________________________________________________

If medication treatments are successful, why is the request for release necessary?

____________________________________________________________________________

____________________________________________________________________________

____________________________________________________________________________

____________________________________________________________________________
Please indicate below (by circling or marking) your recommendations regarding housing accommodations for this student. Please note that the accommodations marked with an asterisk (*) are extremely limited and will only be considered for students meeting ADA criteria. Housing accommodations are based upon the student’s functional limitations and level of need.

Year-round air conditioning * Seasonal air conditioning Single room
No extended housing Centrally located* Close to dining
Wheelchair accessible* Close to bathroom Kitchen*
In-room private bath* Limited stair climbing (how many floors? ____)

Further explanation for any of the above:

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

Name of Professional (please print):

______________________________________________________________________________

Signature of Professional: ___________________________ Date: ______________________
License No. ___________________________ State: ______________________
Address:
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
Phone: ___________________________ Fax: ___________________________