



Housing Accommodation – Requests due to Medical Condition or Disability

Dear Student,

In an effort to effectively respond to student requests for housing modifications or accommodations, the University has created the Housing Request Committee. The committee is made up of a group of JMU professionals representing the Office of Disability Services, the University Health Center and the Office of Residence Life.

In order to fully evaluate your request, the Housing Request Committee, will need documentation of your condition or disability. Documentation should be current and comprehensive in light of the request and consist of an evaluation by an appropriate professional that describes the current functional impact of the condition or disability as it relates to the housing modification or accommodation requested.

Documentation provided will be used by the Committee to evaluate your request. The Committee will generate a list of potentially reasonable modifications or accommodations based on:

- Information provided by the diagnosing professional
- Potential effectiveness
- Potential for an undue financial or administrative burden
- Timeliness of the request and room availability

JMU reserves the right to request additional documentation if the information submitted appears to be outdated, inadequate in scope, or content, does not address the student's current level of functioning or substantiate their need for modifications or accommodations.

Students will be notified in writing of the Committee's decision.

Deadlines:

A fully completed "*Certification of Condition or Disability Form*" must be received by the Housing Request Committee by the dates published in the One Book. Requests received after the stated deadlines will be considered on an as available basis. Deadlines are set annually in keeping with other housing application deadlines, typically early March for returning students and May for incoming freshman.

The attached "*Certification of Condition or Disability Form*" has been developed to assist you in working with your diagnosing or treating professional to prepare the information needed to evaluate your request. Please complete the attached form and return it to the Housing Request Committee. A completed Health Record should also be on file in the University Health Center.

Questions about the Housing Accommodation Request process may be directed to the Housing Request Committee at SHRC@jmu.edu or by contacting the Office of Residence Life - Phone (540) 568-4663.

Housing Request Committee
James Madison University
MSC 1009 / Student Success Center, Suite 1202
Harrisonburg, VA 22807
SHRC@jmu.edu



Housing Accommodation – Requests due to Medical Condition or Disability

Documentation of Medical Condition or Disability Form PART 1 of 2

To Be Completed by the Student

1. The Housing Request Committee will be unable to consider any requests for housing modifications or accommodations until the requested information is received and a Health Record is on file in the Health Center.
2. Fill out your name, address, Student ID / SSN, date of birth, in the space provided below.
3. Have a qualified diagnosing/treating professional, **who is familiar with your condition or disability** complete the PART 2 of the form. You may need to explain the purpose of the form to your clinician. *Note: The diagnosing/treating professional should not be an immediate family member.*
4. Return this form, along with any supporting documentation to:

Housing Request Committee (Medical / Disability Request)
James Madison University - MSC 1009
Student Success Center, Suite 1202
Harrisonburg, VA 22807

or Fax forms to: 540-568-7099

Please Print:

Student Name: _____
 Student ID#: _____ Date of birth: _____ Sex: M F
 Address: _____
 City, State, Zip: _____
 Home Phone: (____) _____ - _____
 E-Mail Address: _____
 Current Resident Hall/PO Box: _____
 Current JMU/Local Phone: _____
 Current Academic Level: Incoming Freshman Incoming Transfer
 Freshman Sophomore Junior Senior

Do you have a Health Record on file in the University Health Center? Yes No

• Describe Your Housing Request:

This request is for housing in the FALL /SPRING SUMMER of the year _____.

<input type="checkbox"/> Modified equipment for deaf or hard of hearing persons, including TTY and fire alarms.	<input type="checkbox"/> Wheelchair accessible dorm
<input type="checkbox"/> Avoid stairs and/or must be on a lower level	<input type="checkbox"/> Wheelchair accessible shower
<input type="checkbox"/> Lowered closet rods	<input type="checkbox"/> Must have wheelchair access to elevator
<input type="checkbox"/> Other:	<input type="checkbox"/> Wheelchair accessible furnishings (i.e. desk)

Explain how your request relates to your medical condition or disability.

To be complete, requests must include the student's signature affirming agreement and clear responses to the questions above. Requests must be submitted in a timely fashion according to the deadlines for housing applications for each academic term.

As indicated by the signature below, the student submitting this request agrees that any information relevant to consideration of the request may be reviewed by appropriate University staff in evaluation and in any subsequent provision of accommodations.

Student's signature

Date



Housing Request Verification of Medical Condition or Disability Form - PART 2 of 2

To Be Completed by Diagnosing/Treating Professional
VERIFICATION OF MEDICAL or PSYCHOLOGICAL CONDITION OR DISABILITY
To Support Student's Request for Accommodations of Disability at the University

1. Fill out your name, certification and contact information below.
2. Provide information addressing the nine separate items listed below by filling out this form or providing a printed narrative on your official letterhead.
3. Should the information requested below be contained in a current, comprehensive evaluation report – please attach a copy of the report to this form.
4. *Please note: The patient should not be an immediate family member.*

Qualified Diagnostic/Treating Professional Information:

Please type or print. Thank you.

Name: _____

Title: _____

Certifications or Licensure: _____

Address: _____

City, State, Zip: _____

Telephone Number: _____ Fax Number: _____

Email: _____

The report from a current, comprehensive, age-appropriate psycho-educational evaluation is most appropriate to support accommodations for Learning Disabilities and ADD/ADHD. Students are also invited to submit other relevant information about their history and need of academic accommodations such as IEP's, relevant military records, or evaluations for assistive technology.

Date: _____

Name of Student (PLEASE PRINT): _____

Date of Birth: _____ Gender: M F

Address: _____

Phone: _____

Please answer these questions with the goal of providing information that will help the school to understand the student's current level of functioning, limitations, and associated need for accommodations of disability. You may also report on letter head as needed. (If mandatory fields are left blank, more information may be requested in order to understand the student's difficulties and associated need for accommodation or modifications at the university level. If diagnostic process is not complete, share something about what is known of the patient's symptoms and problems.)

Student Name: _____

1. MANDATORY:

Diagnosis/Description of Medical Condition, Psychological Disorder or Primary Disability.

DIAGNOSIS:
Original date of diagnosis:
Date of most recent treatment or diagnosis:

2. MANDATORY: The prognosis for the medical condition or disability above is:

- Permanent/Chronic
- Long term: 6-12 months
- Short-term/Temporary: 6 months or less Expected duration: _____
- Episodic (please describe below)

What is the severity of the condition? Please check one:

- Mild Moderate Severe

Describe the expected **progression or stability** of the condition over time, particularly the next four to five years. (This description should provide an estimate of the change in the functional limitations of the disability over time and/or recommendations concerning the predictable needs to review circumstances to ensure needs are appropriately addressed.)

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“Major bodily functions” include, but are not limited to, functions of the immune system, normal cell growth, digestive, bowel, bladder, neurological, brain, respiratory, circulatory, endocrine, and reproductive functions.

“Major life activities” include, but are not limited to, caring for oneself, performing manual tasks, seeing, hearing, eating, sleeping, walking, standing, lifting, bending, speaking, breathing, learning, reading, concentrating, thinking, communicating, and working.

3. MANDATORY: Does this individual’s condition substantially impact major bodily functions or limit him or her in a major life activity?

- NO** *If no, accommodations are likely not needed.*
- Yes -- If yes, please specify what functions or activities are involved and the severity of current impairment.**

Student Name: _____

Functional Limitations and Current Impact or Severity:

Life Activity/Functions	Negligible	Moderate	Substantial	Don't Know
Seeing				
Hearing				
Walking				
Sitting				
Standing				
Learning				
Reading				
Concentrating				
Thinking				
Organizing information/materials				
Managing Internal Distraction				
Managing External Distractions				
Self-care				
Speaking				
Sleeping				
Breathing				
Working				
OTHER (Please specify):				

To help in determining the need for accommodations, please describe the positive and negative impact of mitigating measures including current treatment(s)/therapy, assistive devices, and prescribed medications. ***(“For example, someone with diabetes may need breaks to take insulin and monitor blood sugar levels, and someone with kidney disease may need a modified work schedule to receive dialysis treatments. On the other hand, if an individual with a disability uses a mitigating measure that results in no negative effects and eliminates the need for a reasonable accommodation, a covered entity will have no obligation to provide one.”***
http://www.eeoc.gov/laws/regulations/ada_qa_final_rule.cfm

Student Name: _____

4. **MANDATORY: Student's History and use of Academic Accommodations:** Please share information about accommodations that have been used effectively in the past. If accommodations have not been used or approved in the past, what has occurred to prompt the current recommendation for accommodations (as reflected in #6 below)?

Psychosocial History: Provide relevant information obtained from the student/parent(s)/guardian(s) regarding the student's psychosocial history (e.g. often engaged in verbal or physical confrontation, history of not sustaining relationships, history of employment difficulties, history of educational difficulties, history of risk-taking or dangerous activities, history of impulsive behaviors, social inappropriateness, history of psychological treatment, etc.).

5. **MANDATORY: Please list any academic, housing, or other accommodation(s) you recommend and the reason(s) for the recommendation.** Accommodation recommendations should flow logically from the current functional impairment(s) that point to the need for modifications. Explain how accommodation(s) or modifications will ease the impact of the disability in the collegiate environment.

Student Name: _____

6. Please use the space below (and additional sheets as needed) to provide any information that will be helpful to University staff in considering the accommodations that you are recommending. You may choose to address these questions:

- a. Is impact of the condition threatening if the request is not met?
- b. Is there a negative health impact that may be permanent if the request is not met?
- c. Is the request an integral component of a treatment plan for the condition in questions?
- d. What is the likely on academic performance if the request is not met?
- e. What is the likely impact on social development if the request is not met?
- f. What is the likely impact on the student's level of comfort if the request is not met?

All recommendations are considered. Potentially effective alternatives may be considered as needed. Decisions are made based on the nature of the disability and functional limitations, reasonableness of the request, academic integrity and available housing.

Signature indicates that complete records are on file with the Treating Clinician at the below location and will be available for clarification upon request, and the Treating Clinician is not a family member of the student.

Signature of Treating Clinician Date

Name (Please Print)

Please Return To: Valerie Schoolcraft, Director
Office of Disability Services
MSC 1009
Student Success Center, Suite 1202
Harrisonburg, VA 28807
Phone: 540.568.6705 FAX: 540-568-7099

Portions of this document were adapted from a similar form developed by the Office for Disability Services at the Ohio State University, with permission, June 2012.