SOUTHEAST MISSOURI
STATE UNIVERSITY · 1873

Office of Residence Life

Housing Request Due to Medical, Physical, Psychological Reasons

In order to evaluate how to meet your special needs housing, we require specific information from both you and your healthcare provider. You must also fill out and sign the Authorization to Receive Health Care Information. This provides the university permission to speak with the healthcare provider if we have questions regarding recommendation provided for accommodation. Your healthcare provider must complete the rest of this form, sign it, and return the completed packet to the Office of Residence Life.

Housing Procedure for Accommodating Special Medical Needs

The residential experience is an essential part of the Southeast Missouri State University experience. For this reason, the Office of Residence Life works in conjunction with the Office of Counseling and Disability Services to determine the most appropriate housing accommodation for a special needs student. Students requesting special accommodations for medical, psychological or other physical disability related conditions must register with the Office of Counseling and Disability Services and have to meet the Americans with Disabilities Act and/or Section 504 of the Rehabilitation Act of 1973. Information provided for special consideration is kept confidential and is only used during the evaluation.

Students should submit a statement outlining their request for accommodations. In addition to the basic documentation about a medical condition, further recommendations from a treating professional are welcome and will be given consideration in evaluating a request.

Requesting Contract Cancelations due to Special Medical Concerns

Requests to cancel housing contracts due to a medical, psychological, or physical disability requires completion of the ***Petition to Terminate Housing Contract*** from the Office of Residence Life. The documentation for release must include reasoning that is supported by appropriate medical documentation and must substantiate the claim that University housing cannot meet the medical need of the student. If a different location on campus will negate or minimize the effects of the medical condition, cancellations will not be approved.

Factors considered when evaluating special housing requests:

- Is the request an integral component of a treatment plan prescribed by a healthcare provider for the condition in question?
- Is space available to accommodate 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?
- Is the request to live off campus based upon specific evaluation of the residence halls at Southeast Missouri State University?
    - Not all halls are the same, therefore a letter simply saying a student should live off campus, absent specific reasons why the residence hall is not supportive of the student's needs, will not be granted.

Authorization to Receive Health Care Information

Complete the top portion of the form below. Fill out and sign the Authorization to Receive Health Care Information below. This provides the university permission to speak with your healthcare provider if we have questions relating to his/her recommendation for accommodation(s). Have your health care provider complete the rest of this form, sign it, and fax or mail the packet to the Office of Residence Life.

Student Completes This Section:

(Please Print or Type):

Student Name: ____

(Last) (First) (MI)

S0 Number: S0____

Date of Birth: ___________________________ Gender: ____ Male ____ Female

Home Address: ____

Campus Address (if applicable):____

Phone: ___________________________ E-Mail Address: _____________________________

I have registered with the Office of Disability Services and/or the Center for Health & Counseling on campus:

Yes ☐ No ☐

I authorize the Office for Residence Life to receive information from the provider below. I also authorize my provider to discuss my condition(s) with the Office for Residence Life.

Name of Provider: ____

Address (Street, City, State, and Zip): ____

____

Student's Signature: ______________________________ Date: _______________________

Medical/Health Care Provider Completes and Signs Section Below:

STUDENT'S NAME**:** ____

Provider Completes the Section Below:
Southeast Missouri State University provides accommodations and support services to students with diagnosed disabilities. A student's documentation regarding their condition must demonstrate they have a disability covered under the Americans with Disabilities Act (ADA; 1990).*
***The ADA defines a disability as a physical or mental impairment that substantially limits one or more major life activities.**

To determine eligibility for services and accommodations, this office requires current and comprehensive documentation of the student's condition from a licensed clinical professional or healthcare provider that is familiar with the history and functional limitations of the student's condition(s). The provider completing this form **cannot** be a relative of the student. **Items 1 thru 11 must be completed in full.** If space provided is not adequate, please attach a separate sheet of paper(s) as necessary. The provider may also attach a report providing additional related information.

<u>This form must be filled out in entirety or will be returned to the student without a decision being rendered:</u>

1) What is your current medical condition/diagnosis? ____
____

2) Please select one: Mild ☐ Severe ☐

Moderate ☐

Expected duration of the condition:

Temporary ☐ Permanent ☐

Stable ☐ Progressive ☐

Service or Therapy Animal needed?

Yes ☐ No ☐

3) What is the date of the most recent evaluation? ____

4) How long have you been working with the student regarding this diagnosis or impairment?
____

5) How long has the student had this condition?
____

6) Please describe the symptoms related to the medical condition that cause significant impairment to a major life activity and please relate the symptoms to housing accommodations requested: (i.e. sleeping, hearing, walking…)
____
____
____

7) List the current medication(s) the student is currently being prescribed and any adverse side effects:

____
____

8) Are there any significant limitations to the student's functioning directly related to the prescribed medications?

Yes ☐ No ☐

If you chose **yes**, please describe the symptoms related to the student's condition that cause **significant** impairment in a major life activity:

____
____
____

9) Are the medication treatments successful?

Yes ☐ No ☐

If yes, are additional accommodations necessary?

____
____
____

10) Does the student have a disability* as a result of this condition?

Yes ☐ No ☐

If yes, please state specific recommendations regarding housing accommodations for this student, and a rationale as to why these housing accommodations are warranted based upon the student's functional limitations. Indicate why the housing accommodations you recommend are necessary (e.g., if you request a personal bathroom, state the reasons for this request related to the student's disability).

____
____
____

11) Please describe how the housing configuration sought is the only way for the student to have access to residential housing:

____
____
____

The provider may also send a report that provides additional related information.

❑ I am verifying that the named student information is correct, that the student is a patient that I have been treating, and that **I am not a relative of the student**.

Signature of Provider: ______________________________ Date: _________________________

(Please print) Name/Title: ____

Address: ____

Phone: ____

Email: ____

Return Address:
Southeast Missouri State University
Office for Residence Life
One University Plaza MS 0055
Cape Girardeau, MO 63701

Fax 573-651-2557