Modified Housing/Dining – Disability Verification Form

DISABILITY ACCESSIBILITY RESOURCES CENTER

University of New Haven

To be completed by Health Care Provider ONLY! (Please Print or Type)

The University of New Haven strives to provide a variety of housing and dietary arrangements to suit our students' needs. We recognize, however, that there are circumstances where specific requests and accommodations may need to be considered. In order for us to determine eligibility for these accommodations and services, a student must submit documentation of a disability as defined in Americans with Disabilities Act Amendment Act (ADAAA) and Section 504 of the Rehabilitation Act as physical or mental impairment that **substantiall**y limits one or more major life activities.

To consider this request, the Accessibility Resources Center (ARC) requires that this form be filled out by a qualified professional who has firsthand knowledge of the student's condition and is an impartial individual who is unrelated to the student.

Student's Name _____

Last ***First*** ***MI***

Please complete all items from 1 to 7 in full, except for Item 2, which must be filled out only if you are a student requesting modifications to housing or dining services related to Dietary Needs.

1. Medical Condition/Diagnosis: _____
   a) Date Diagnosed: _____
   b) Date of last appointment regarding this diagnosis: _____
   c) If you are aware of any impacts directly related to the student's medical condition/diagnosis in these areas, please specify. ***Indicate if this condition significantly limit one or more of the following major life activities.*** Functional Limitations on major life activities should be determined WITHOUT consideration of mitigating measures (i.e. medication, eyeglasses, hearing aids, etc.). If condition is episodic in nature, level of functioning should be assessed based on active phase of symptoms. Please indicate any mitigating measures and their impact under COMMENTS if impact is different when mitigated.

Functional Limitation	Mild	Moderate	Severe	NA	Comments – Please Explain
Caring for Oneself					
Performing Manual Tasks					
Seeing					
Hearing					
Sleeping					

Eating					
Speaking					
Walking					
Standing					
Breathing					
Major Bodily Function					
Other					

d) For Asthma, please indicate severity below:

☐ Intermittent ☐ Mild Persistent ☐ Moderate Persistent ☐ Severe Persistent

e) How long is this student's condition indicated above likely to persist?

☐ 0-6 months ☐ 6 months - 1 year ☐ 1 – 5 years ☐ lifelong

2. ***Complete ONLY if the student is requesting Modifications to Housing and/or Dining related to specific dietary needs*** * Please explain the specific dietary needs of the student as related to the condition/diagnosis:

a) Student must avoid certain foods (please explain/list foods in detail): _____

_____

_____

b) Student has specific dietary needs which require eating at specified times and/or time intervals (please explain in detail):

_____

_____

c) Other specific dietary need (please explain in detail): _____

_____

_____

3. Has the student been hospitalized for this condition? ☐No ☐Yes (If Yes, please complete the following)

a) How frequently has student been hospitalized? _____

b) Date of most recent hospitalization: _____

c) What exacerbated the condition to the point of hospitalization? _____

_____

4. List the student's current medication(s) with adverse side effects experienced by this student that may impact the student in the residential setting.

_____

_____

_____

5. Your recommendations can be helpful in our assessment of need and/or appropriate accommodations. Please state the ***specific suggested housing configuration or dining accommodations for this student along with a rationale*** as to why these accommodations are warranted based on the student's ***current*** functional limitations. (e.g. If you suggest a private bathroom, state the reasons for this request as related to the student's condition.)

_____

_____

_____

6. If current treatments (e.g. medications) are successful, why are the above recommended accommodations necessary?

_____

_____

_____

7. Are there any unusual circumstances surrounding this condition that would help us make an appropriate decision regarding accommodations for this student?

_____

_____

_____

Please attach any additional information you feel will be helpful to us in assisting the student with his/her request for consideration of modification to housing or dining options.

Name of Certifying Professional: _____

Name of Agency: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone: _____ Fax: _____

Professional Title: _____

License/Certification Number and Issuing State: _____

Signature of Certifying Professional

NOTE: *Final determination of appropriate accommodations will be conducted by the Accessibility Resources Center in accordance with the mandates of the Rehabilitation Act of 1973 and the Americans with Disabilities Act, as amended, as well as court rulings and Department of Education Office of Civil Rights rulings related to these two laws*.

You are completing this form for the student named above who has indicated that they have a disability or medical condition and will require reasonable accommodation(s) to participate in a program or activity at the University of New Haven. In order for the university to proceed, we may require additional information after reviewing the information provided in this document. The student understands that the Accessibility Resources Center staff or a designee may request additional information after reviewing this document and upon submission of their application.

Please list the best times to contact you:

_____

***I certify, by my signature below that this information is true, accurate, and complete.**

_____ _____

Signature of Certifying Professional Date

This document may not be released without the student's written permission, except as permitted by the Family Educational Rights and Privacy Act (FERPA). FERPA allows disclosure to university staff or faculty with a legitimate educational interest and grants the student the right to access this document.

Thank you for your assistance in completing this form

If you have any questions regarding the nature of this information needed for students with disabilities, please call the Accessibility Resources Center at (203) 932-7332, Mon. through Fri. from 8:30 A.M. to 4:30 P.M.

This form and any supplemental documentation can be submitted to Accessibility Resources Center at arc@newhaven.edu, or via fax (203) 931-6082, or send via mail to:

University of New Haven
Accessibility Resources Center
300 Boston Post Road
West Haven, CT 06516