ST. JOHN FISHER UNIVERSITY

Medical Housing Accommodation Request

Student Instructions

Please only complete Section 1 of this form. When Section 1 is complete, give the form to your healthcare provider to complete Section 2. Once your provider completes Section 2, you may then submit the completed form to the Health and Wellness Center.

Submission Deadline
Housing accommodation requests and supporting documentation for students must be received by:

- *For Incoming Students:* June 1 for the following fall semester.
- *For Returning Students:* February 28 for the following fall semester.

Submit the Completed Form
Please follow the instructions in Section 3 to submit the form to the Health and Wellness Center.

Request Review Process and Communication
Once your accommodation request is submitted to the University, it will be reviewed by the Accommodations Review Committee. In the event the documentation provided is incomplete or additional information is needed from you, a member of the Committee will email you. As part of the process, the healthcare provider who completes Section 2 of the form may be contacted by a Health and Wellness Center representative serving on the Committee if additional information is needed.

After your accommodation request is reviewed and a decision is determined, a member of the Committee will email you outlining what housing accommodation(s) (if any) will be made.

More Information
Please visit the residence hall accommodations website for more information about types of accommodations, the accommodations process and information about residence hall living.

Section 1 – Completed by Student

Student Name: _____ **Student ID Number:** @ _____

University Email Address: _____@sjf.edu **Birthdate:** _____ /_____ / _____

Best Contact Number: _____

Which semester are you requesting an accommodation to begin? Fall _____ or Spring _____
YYYY YYYY

Section 1 Continued – Completed by Student

1. **Please describe your condition**:
   Diagnosis, how long you have experienced this, current treatment/management, prognosis

2. **Describe how your condition impacts you daily and how you anticipate it will impact you while living on-campus:**

3. **Describe the housing accommodation you are requesting:**

4. **Describe how the housing accommodation you are requesting is connected to the treatment plan for your condition:**

Student Signature: _____ **Date:** _____ /_____ / _____

Parent/Guardian Signature: _____ **Date:** _____ /_____ / _____
Only required if student is under 18

HIPAA Privacy Authorization

Authorization for Use or Disclosure of Protected Health Information

As part of the process, the healthcare provider who completes Part 2 of the form may be contacted by the Committee if additional information is needed. In order to access this information, a medical information release is required.

I authorize the following provider to release Information to the St. John Fisher University Health and Wellness Center:

Name of Provider or Facility: _____

Address: _____

Phone: _____ **Fax:** _____

Purpose of Request: Medical Housing Accommodation Request

I authorize the release of the following information, including discussion of such information with representatives of the St. John Fisher University Health and Wellness Center:

_____

e.g. "documentation and information related to _____ diagnosis or condition."

Expiration: This authorization shall be in force and effect until _____ (date or event), at which time the authorization expires.

By signing below I indicate that I understand that:

- I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization.
- my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization.
- information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

Student Signature: _____ **Date:** _____ /_____ / _____

Parent/Guardian Signature: _____ **Date:** _____ /_____ / _____

Only required if student is under 18

Please give this form to your healthcare provider to complete Section 2. The provider who completes Section 2 should be the diagnosing/treating specialist who can best speak to your needs and medical condition.

Section 2 – Completed by Healthcare Provider

This section must be completed by a licensed healthcare provider. To assist the St. John Fisher Accommodations Review Committee in evaluating the medical necessity for a housing accommodation for the student, please be specific and provide the following information. Inadequate information, incomplete answers and/or illegible handwriting will delay the eligibility review process by necessitating follow up contact for clarification.

The Americans with Disabilities Act (ADA) defines a disability as a physical or mental impairment that substantially limits one or more major life activities. The information you provide must show how the relationship between the functional limitations that result from the student's diagnosis/medical condition and the associated impact to the student in a university residential setting would benefit from an accommodation that directly supports the treatment plan or management of the diagnosis/medical condition..

Provider Name: _____ **Title:** _____

License/Certification Number: _____

Office/Group Name: _____

Address: _____

Phone: _____ **Fax:** _____

1. **How long has the student been under your care and how often do you see the student?**

2. **What is the diagnosis(es):** _____

3. **What is the initial date of the diagnosis(es):** _____

4. **What is the date you have last been in contact with the student for an appointment related to the medical condition(s) described above:** _____

5. **Describe the severity and impact of the medical condition(s) indicated above.**

6. **What is the expected duration of this medical condition(s)?**

Section 2 Continued – Completed by Healthcare Provider

7. **Describe any situations or environmental conditions that may exacerbate the medical condition(s).**

8. **Describe the medical treatment plan for this condition(s).**

9. **Describe the steps that the student has taken (or will take) to personally address and support their needs?** *(Examples may include use of medically supported strategies/techniques, adaptive equipment and technology, services and resources available to the student)*

10. **Describe how the medical condition(s) and or treatment plan(s) affect the student's ability to live in on-campus housing?**

11. **Major Life Activities Assessment**

Using a checkmark or "X", please identify the degree to which each of the following life activities are impacted by the medical condition.

Life Activity	*N/A or None*	*Mild*	*Moderate*	*Severe*
Ambulating				
Breathing				
Eating				
Hearing				
Managing Distractions				
Performing Manual Tasks				
Seeing				
Self-Care				
Sleeping				
Social Interactions				
Speaking				
Stress Management				
Toileting				
Other:				

12. Based on the diagnosis and assessment above, please describe the functional limitation and corresponding housing accommodation that is being recommended.

Healthcare providers may make recommendations for accommodations however, documentation must make explicit connections between functional limitations and recommended accommodations.

	Functional Limitation Due to Medical Condition:		***Corresponding Accommodation for Housing:***
1.		➡	
2.		➡	
3.		➡	
4.		➡	
5.		➡	

13. Additional Information or Attachments

If you wish to include any additional information or information, please attach it to this form.

Provider Signature: _____ **Date:** _____ / _____ / _____

Please return this form to the student.

Section 3 – Submitting the Housing Accommodation Request Form

Please return the completed request form (both sections 1 and 2) to the St. John Fisher University Health and Wellness Center:

Mail or In Person
Health and Wellness Center
St. John Fisher University
3690 East Avenue
Rochester, NY 14618

Fax
(585) 385-8299

Upload a Scanned File to the Student Patient Portal

1. Go to: go.sjf.edu/patientportal
2. Click on "Upload"
3. Select "Housing Accommodation Request Packet" as the document type you are uploading and follow the on-screen instructions to upload the file.