MEDICAL HOUSING ACCOMMODATION PROCESS OVERVIEW

OVERVIEW

The medical housing accommodation application is intended for students who are seeking special housing consideration due to disability or medical necessity. Potsdam reserves the right to amend the Medical Housing Policy and Application at any time.

Once a completed application is submitted to Residence Life, it is reviewed by the Medical Housing Committee, which consists of representatives from Accommodative Services, the Counseling Center, Residence Life/Student Affairs, and Student Health Services. In situations where the accommodation request involves a student's meal plan (to include seeking a release from living on campus), a representative from PACES will also join the committee.

All documentation will be kept confidential, except in consulting with other offices to make a determination on the application and/or as required by law. Information provided is protected by FERPA. No information concerning inquiries about the accommodations or documentation will be released without written consent from the student requesting the accommodation.

The Medical Housing Committee reviews applications based on a number of factors to include the severity of the student's condition and the College's ability to provide a reasonable accommodation. In addition, the committee assesses (1) whether a student has a documented disability that limits one or more major life functions and (2) whether the accommodation that is being requested is medically necessary for the student to be able to attend SUNY Potsdam and/or live in the Residence Halls.

Students should expect a response to their application within fourteen (14) business days of it being received by the Office of Residence Life. Written responses will be sent to the student. Should an application be approved during the academic year, Residence Life will immediately start working with the student on the accommodation. Applications approved for future semesters will be assigned during the appropriate housing time period. **SUNY Potsdam cannot guarantee that it will be able to meet the accommodation needs during the semester or term in which the request is received.**

COMPLETING THE APPLICATION

Please use the following instructions to complete the Medical Housing Accommodation Application.

- **Section 1** needs to be completed by the **student** requesting the medical accommodation.
- **Section 2** needs to be completed by an **appropriate licensed healthcare provider**, which is defined as (but not limited to) a primary physician, nurse practitioner, physician's assistant, licensed mental health professional, etc. The diagnostician must (1) have an established patient relationship with the student, and (2) have provided treatment for the condition. Generally, someone related to the student should not be the one to provide supporting documentation.
- Once both sections are completed, the application can be returned **in person or by mail** to the **Residence Life office** or **emailed** directly to Residence Life at reslife@potsdam.edu.
- **A written response will be sent to the student** through their SUNY Potsdam email address **within fourteen (14) days** of receiving the application.

MEDICAL HOUSING ACCOMMODATION APPLICATION

SECTION 1: TO BE COMPLETED BY THE STUDENT

Student Name: ____

SUNY Potsdam ID #: P0________________________ Date of Birth: ___________________________________

SUNY Potsdam email:____________________@potsdam.edu Cell Phone Number: (______) ______________________

Semester that you are requesting the accommodation to begin: Fall ________ Spring ________ Summer ______

Granting your request for a disability-related housing assignment may limit your ability to choose your roommates, building or floor; students without disabilities may be eligible to live in the assigned space only if they earn that option through the existing housing process.

1. Please briefly describe the condition/diagnosis for which you are requesting accommodative housing.

   How long have you been impacted by this condition?

   How does this condition impact your daily life?

   How does your condition affect you in a residential setting (e.g. residence halls)?

   How have you managed without this type of accommodation prior to this application (medical single, etc…)?

2. Please check the accommodation(s) you are requesting (this does not guarantee approval nor availability):
   - Medical Single
   - Release from campus housing (live off campus)
   - Wheelchair accessible toilet, sink, and shower
   - Wheelchair accessible bedroom
   - Housing on a first floor due to mobility challenges.
   - Bedroom with visual alert for fire alarm
   - Housing with elevator access
   - Other: _______________________________________
     ____
     ____

I authorize SUNY Potsdam to receive information related to my disability from my medical provider. I understand that once submitted, the documentation included in my application will be reviewed by members of the Medical Housing committee. The statements and documentation in my application are accurate as I know them. I understand that providing false information would constitute a violation of SUNY Potsdam's Student Code of Conduct and Responsibilities and might result in disciplinary action.

____ ______________________

Student Signature Date

SUNY POTSDAM OFFICE OF RESIDENCE LIFE
44 PIERREPONT AVENUE
POTSDAM, NY 13676

PHONE: 315-267-2350
EMAIL: reslife@potsdam.edu

MEDICAL HOUSING ACCOMMODATION APPLICATION

SECTION 2: TO BE COMPLETED BY THE LICENSED HEALTHCARE PROVIDER

The student is applying for a medical accommodation within SUNY Potsdam's Residence Life program due to a disability and/or diagnosed medical/psychological condition. In order for us to establish whether this student qualifies for a medical accommodation, we need your assessment and diagnosis of the student.

This form needs to be completed by an **appropriate licensed healthcare provider**, which is defined as (but not limited to) a primary physician, nurse practitioner, physician's assistant, licensed mental health professional, etc.
The diagnostician must (1) have an established patient relationship with the student, (2) have provided treatment for the condition. Generally, someone related to the student should not be the one to provide supporting documentation.

Once completed, the application can be returned in person or by mail to the Residence Life office or emailed directly to Residence Life at reslife@potsdam.edu.

Patient/Student Name: ____ Today's Date: _______________

What is the student's current diagnosis, and how long have they had it? ____________________________________

What is the anticipated duration of the condition

- [ ] Temporary: Condition has a clear recovery date (e.g. broken leg); Anticipated duration: _____
- [ ] Ongoing: There is not a clear recovery date, but student may see improvement during their time at college.
- [ ] Permanent: There is little, to no, possibility of a recovery.

How long has the student been under your care? ____

What are the dates of the last two appointments that you had with this student? ____________ ____________

Please describe how this individual's major life activities are impacted or limited by the medical condition(s)?

Are these limitations substantial in comparison to most people?

MEDICAL HOUSING ACCOMMODATION APPLICATION

How has the student managed their symptoms that are the basis for the request in the past?

Please check the accommodation(s) that is/are medically necessary (this does not guarantee approval nor availability):

- Medical Single
- Release from campus housing (live off campus)
- Wheelchair accessible toilet, sink, and shower
- Wheelchair accessible bedroom
- Housing on a first floor due to mobility challenges
- Housing with elevator access
- Bedroom with visual alert for fire alarm
- Other: ______________________________________
  ____
  ____

How would this specific housing arrangement alleviate/ameliorate the specific symptoms the individual is experiencing? (Please be specific in explaining how each housing request is a medical necessity.)

PROVIDER INFORMATION

Provider Name/Title (please print): ____

Clinic Name & Address: ____

Phone Number:__________________________ Certification/License Number: __________________________

Signature:____ Date: __________________________