

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.

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 the 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 two weeks of it being received by the Office of Residence Life. Responses will be sent to the student's SUNY Potsdam email address. 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.

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 diagnostician or qualified clinician**, 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, and (3) be an impartial individual who is not a family member of the student.
- 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@potsgdam.edu.
- **A response will be emailed to the student** through their SUNY Potsdam email address **within two weeks** 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: _____@potdam.edu Cell Phone Number: (____) _____

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

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)?

2. Please check the accommodation(s) you are requesting (this does not guarantee approval nor availability):

- | | |
|--|---|
| <input type="checkbox"/> Medical Single | <input type="checkbox"/> Bedroom with visual alert for fire alarm |
| <input type="checkbox"/> Release from campus housing (live off campus) | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Wheelchair accessible toilet, sink, and shower | _____ |
| <input type="checkbox"/> Wheelchair accessible bedroom | _____ |
| <input type="checkbox"/> Housing on a first floor due to mobility challenges | |
| <input type="checkbox"/> Housing with elevator access | |

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

MEDICAL HOUSING ACCOMMODATION APPLICATION



SECTION 2: TO BE COMPLETED BY THE LICENSED DIAGNOSTICIAN OR CLINICIAN

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 diagnostician or qualified clinician**, 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, and (3) be an impartial individual who is not a family member of the student.

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@potsgdam.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.

Please indicate which of the major life activities are moderately or substantially impacted by the student's condition:

- | | | |
|--|--|---------------------------------------|
| <input type="checkbox"/> Breathing | <input type="checkbox"/> Performing Manual Tasks | <input type="checkbox"/> Thinking |
| <input type="checkbox"/> Caring for oneself | <input type="checkbox"/> Reaching | <input type="checkbox"/> Walking |
| <input type="checkbox"/> Concentrating | <input type="checkbox"/> Reading | <input type="checkbox"/> Working |
| <input type="checkbox"/> Hearing | <input type="checkbox"/> Seeing | <input type="checkbox"/> Writing |
| <input type="checkbox"/> Interacting with Others | <input type="checkbox"/> Sitting | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Learning | <input type="checkbox"/> Sleeping | _____ |
| <input type="checkbox"/> Lifting | <input type="checkbox"/> Standing | _____ |
| <input type="checkbox"/> Memorizing | <input type="checkbox"/> Talking | _____ |

How long has the student been under your care? _____

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

MEDICAL HOUSING ACCOMMODATION APPLICATION



Please provide your professional, medical opinion on the medical necessity of the following accommodations based on the student's current diagnosis. If identified as medically necessary, please provide supporting information for consideration.

Accommodation	Assessment of Necessity	Supporting info for Medical Necessity
Medical Single	<input type="checkbox"/> Medical Necessity <input type="checkbox"/> Convenient, but not necessary <input type="checkbox"/> Not needed	
Release from Campus Housing (live off campus)	<input type="checkbox"/> Medical Necessity <input type="checkbox"/> Convenient, but not necessary <input type="checkbox"/> Not needed	
Wheelchair Accessible toilet, sink, shower	<input type="checkbox"/> Medical Necessity <input type="checkbox"/> Convenient, but not necessary <input type="checkbox"/> Not needed	
Wheelchair accessible bedroom	<input type="checkbox"/> Medical Necessity <input type="checkbox"/> Convenient, but not necessary <input type="checkbox"/> Not needed	
Housing on first floor due to mobility challenges	<input type="checkbox"/> Medical Necessity <input type="checkbox"/> Convenient, but not necessary <input type="checkbox"/> Not needed	
Housing with elevator access	<input type="checkbox"/> Medical Necessity <input type="checkbox"/> Convenient, but not necessary <input type="checkbox"/> Not needed	
Bedroom with visual alert for fire alarm	<input type="checkbox"/> Medical Necessity <input type="checkbox"/> Convenient, but not necessary <input type="checkbox"/> Not needed	
Other (please specify):	<input type="checkbox"/> Medical Necessity <input type="checkbox"/> Convenient, but not necessary <input type="checkbox"/> Not needed	

PROVIDER INFORMATION

Provider Name/Title (please print): _____

Clinic Name & Address: _____

Phone Number: _____ Certification/License Number: _____

Signature: _____ Date: _____