

UNION COLLEGE SPECIAL HOUSING ACCOMMODATION REQUEST PROCESS

Union College provides support services and reasonable accommodation to students with medical and/or psychiatric disabilities who qualify under the Americans with Disabilities Act of 1990 and Section 504 of the Rehabilitation Act of 1973.

Students who believe they need a special housing accommodation due to an extreme medical or mental health condition must submit a complete request for review by the accommodations committee.

Please note:

1. Requests will be considered on a case by case basis.
2. Submission of an application does not guarantee that the accommodation request(s) will be granted.
3. Special needs housing requires advanced planning and documentation. Student wishing to apply for housing accommodations must complete the appropriate forms, available on the subsequent pages. Phone calls or letters from providers will not be considered without a completed form.
4. Special needs housing accommodations are intended for individuals with a medical disability, **which substantially limits their ability to function daily** in a residence hall environment. The committee will evaluate whether or not the student would be able to successfully remain enrolled without the requested accommodation.
5. Housing accommodations differ from housing preferences. Student preferences for certain types of housing (ground floor, air conditioning, etc.) cannot be granted, whereas reasonable accommodations are provided to student with documented disabilities.
6. Students will be notified if they have been approved or denied for housing accommodations after the accommodations committee has met.

Documentation Forms:

- | | |
|---|------------------------------|
| • Form A: (to be completed by student) | [all requests] |
| • Form B: (to be completed by physician) | [all requests] |
| • Form C: (to be completed by specialist) | [air conditioning requests]* |

*All requests must include Forms A and B. Students requesting air conditioning must ALSO submit Form C.

A letter from a provider will not be considered as a standalone. Form B must be included.

Students approved for air conditioning due to extreme medical conditions may be required to:

If not housed in College Park Hall or Garnet Commons:

- Provide their own air conditioning unit (Facilities Services will provide specifications)
- Contact Facilities Services through the online work request system to install the air conditioning unit. Students may not install their own unit and must schedule installation with a qualified staff member. We cannot guarantee that your air conditioning unit will be installed on the first day you arrive to campus. Every effort will be made to install units within the first 1-2 weeks of classes.

**Please note: due to the generally mild climate in Schenectady, NY the residence halls (with the exception of College Park Hall and Garnet Commons) are not air conditioned, nor are students permitted to provide air conditioning units for their rooms except in the rare instances of disability. As part of the standard furniture and room arrangements, some student rooms are carpeted. Students with allergies or asthma generally do well in this environment without any special arrangements. If allergies or asthma form the basis of a special housing request, full medical documentation will be required, including skin test results for allergies. Those students whose conditions are substantially limiting to a major life activity must provide detailed medical documentation to show why the condition qualifies as a disability.

UNION COLLEGE SPECIAL HOUSING ACCOMMODATION REQUEST
STUDENT REQUEST (Form A)

This form should be filled out by the student and returned to:

Shelly Shinebarger
Disability Services Office, Union College
Reamer Campus Center, Room 303
shinebas@union.edu
Fax: 518-388-7175

- **Applications will be considered on a case by case basis on a rolling deadline. Students should submit forms prior to housing assignments being confirmed. Forms submitted mid-year or after housing assignments have been finalized cannot be guaranteed for consideration.**
- **All forms will be reviewed by a committee of designated professional staff at Union College.**
- **Submission of an application does not guarantee that the requested accommodation will be granted.**
- **Requests for special housing accommodations may need to be submitted each academic year. The student will be notified in advance if resubmission is required in subsequent years to the original request. In addition, the College, acting in good faith, reserves the right to request updated documentation at any time.**
- **The student agrees that any information provided in conjunction with this request can be reviewed as necessary by appropriate staff to determine the response. In addition, the student grants permission for attending physicians and/or other professional providers to share information as requested by College staff.**
- **Forms with incomplete or unclear responses cannot be considered and will be returned to the student.**
- **Upon submitting this portion of the request (Form A), the student must also have Forms B/C completed by a medical provider and sent to Residential Life. Until all portions of the forms are received, the request cannot be processed. The student is responsible for obtaining and submitting all necessary paperwork.**

PLEASE PRINT OR TYPE

Student Name: _____ Union ID: _____

Cell Phone: _____ E-mail: _____

Permanent Address: _____

_____ Home Phone: _____

Incoming Freshman Transfer Student Returning Student (Class year _____)

By signing below, the student agrees to and understands all terms of the accommodations process as detailed in this document and in the student handbook. **REQUESTS WITHOUT STUDENT'S SIGNATURE (BELOW) CANNOT BE CONSIDERED AND WILL BE RETURNED TO THE STUDENT.**

Student Signature: _____

Date: _____

Current housing assignment (if applicable): _____

UNION COLLEGE SPECIAL HOUSING ACCOMMODATION REQUEST
PHYSICIAN REQUEST (Form B)

SECTION I: TO BE COMPLETED BY STUDENT

Name of Student: _____ Union College ID: _____

Class Year: _____ Email: _____

<p>Consent for Release of Information: I, _____ (student name), give _____ (physician name) permission to provide the information requested to the Committee on Special Accommodations at Union College.</p>	
<p>_____ Student signature</p>	<p>_____ Date</p>

SECTION II: TO BE COMPLETED BY ATTENDING PHYSICIAN OR SPECIALIST - OFFICE STAMP REQUIRED.

*****Physician must specialize in the area of the condition or disability, and not be a friend of the family or related to the student by blood or marriage.*****

Name: _____

Specialty: _____ Phone: _____

Address: _____

City: _____ State: _____ Zip: _____

License/Certification Number and State of Licensure: _____

Are you the primary care physician for this patient: _____

Date of most recent office visit: _____

How long have you treated this patient? _____

Medical diagnosis(es): Please include ICD9-CM OR DSM-IV TR Axis codes		
	Expected Duration:	Prognosis:
Date of:	Permanent, Temporary,	Progressive, Stable,
Diagnosis onset:	Remitting/Relapsing	Guarded

PHYSICIAN REQUEST (Form B, page 2)

What medications are currently prescribed for this patient?			
Medication:	Dosage:	Daily or PRN:	Side effects experienced by patient (if applicable):

Please indicate the <u>current functional limitations</u> of the patient: (check all that apply).		
Functional limitation:	Effect on functioning:	Degree of limitation:
<input type="checkbox"/> Hearing (include audiogram if applicable)		<input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe
<input type="checkbox"/> Vision (include acuity levels if applicable)		<input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe
<input type="checkbox"/> Speech		<input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe
<input type="checkbox"/> Manual		<input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe
<input type="checkbox"/> Ambulation		<input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe
<input type="checkbox"/> Motor Coordination		<input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe
<input type="checkbox"/> Activities of Daily Living		<input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe
<input type="checkbox"/> Endurance		<input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe
<input type="checkbox"/> Respiratory		<input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe
<input type="checkbox"/> Climatic/Environment		<input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe
<input type="checkbox"/> Concentration		<input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe
<input type="checkbox"/> Memory		<input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe
<input type="checkbox"/> Sleep Disturbance		<input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe
<input type="checkbox"/> Social Interaction		<input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe
<input type="checkbox"/> Eating Disorder		<input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe
<input type="checkbox"/> Other		<input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe

PHYSICIAN REQUEST (Form B, page 3)

Please list any specific accommodations or other services you recommend to address these.

Please use this space to provide any other information you believe will be helpful to us in assisting your patient in his or her academic endeavors at Union College.

Signature of physician/medical care provider: _____

Date: _____

Office Stamp: _____

**Please return this form to: Union College
ATTN: Shelly Shinebarger
Disability Services Office, Reamer 303
807 Union Street
Schenectady, NY 12308**

OR EMAIL to: shinebas@union.edu

OR FAX to: 518-388-7175

UNION COLLEGE SPECIAL HOUSING ACCOMMODATION REQUEST
AIR CONDITIONING REQUEST DUE TO EXTREME MEDICAL CIRCUMSTANCES (Form C)

SECTION I: TO BE COMPLETED BY STUDENT

Name of Student: _____ Union College ID: _____

Class Year: _____ Email: _____

Consent for Release of Information: I, _____ (student name), give
_____ (physician name) permission to provide the information
requested to the Committee on Special Accommodations at Union College.

Student signature

Date

***SECTION II: TO BE COMPLETED BY ATTENDING ALLERGIST OR MEDICAL SPECIALIST.
OFFICE STAMP REQUIRED.***

******Physician must specialize in the area of the condition or disability, and not be a friend of the family or related to the student by blood or marriage.******

Please Note: Due to the generally mild weather in upstate NY the residence halls are not air conditioned, nor are students permitted to provide air conditioners for their rooms except in rare instances of disability. As part of the standard furniture and room arrangements, student rooms may be carpeted. Students with allergies or asthma generally do okay in this environment without any special arrangements. If allergies or asthma form the basis of a special housing request, full medical documentation will be required including skin test results for allergies. Those students whose conditions are substantially limiting to a major life activity must provide detailed medical documentation to show why the condition qualifies as a disability.

Name: _____

Specialty: _____ Phone: _____

Address: _____

City: _____ State: _____ Zip: _____

License/Certification Number and State of Licensure: _____

Date of most recent office visit: _____

How long have you treated this patient for an allergic or other significant medical condition?

Type of allergy or significant medical condition:

**Please give the diagnosis, functional limitation, recommendation regarding accommodation needs and your justification for this recommendation on the attached forms.
(No prescription pad paper please)**

PHYSICIAN REQUEST (Form C, page 2)

Section III: ASTHMA

(A) Current Diagnosis (select one)

- Exercise Induced Asthma
- Intermittent Asthma
- Persistent Asthma
- Other (please define) _____

(B) Current Asthma Medications (please note medication name, dosage, and how often student takes)

- Short-Acting Beta Agonists

- Long-Acting Beta Agonists

- Inhaled Corticosteroids _____
- Other _____

(C) Please check any of the following which are true for your patient (dates required)

- History of severe asthma exacerbations requiring emergency care (most recent date) _____
- Prior intubation for asthma _____
- Hospital admission for asthma (most recent hospitalization date) _____
- Prior office visits for asthma exacerbation (most recent 3 visit dates) _____, _____, _____
- Prior use of IM or oral corticosteroids for asthma (most recent date prescribed) _____
- Currently requires more than 2 canisters of short-acting beta agonist per month

(D) Are symptoms: ___ continuous ___ intermittent ___ seasonal ___ other (please explain below)

(E) Severity of symptoms: ___ mild ___ moderate ___ significant ___ other (please explain below)

(F) Description of the student's functional limitations or behavioral manifestations in a college residence hall setting:

(G) MEDICAL PROVIDER COMMENTS: Please list your specific recommendations for reasonable housing accommodations for this student in a college residence hall

Signature of Physician/Medical Care Provider: _____

Date: _____

PHYSICIAN REQUEST (Form C, page 3)

Section III: ALLERGIES

(H) Current Diagnosis (select one)

- Allergic Conjunctivitis
- Allergic Rhinitis (Circle one): Seasonal Perennial
- Other (please define):

10. Current Allergy Medications (please note med name, dosage, and how often student takes)

- Antihistamines:

- Steroid Nasal Inhaler:

- Other:

11. Please check any of the following which are true for your patient (dates required)

- Allergies documented by skin testing or other diagnostic testing (most recent date)

- Prior or current immunotherapy (allergy shots)

11. Are symptoms: ___ continuous ___ intermittent ___ seasonal ___ other
(please explain below)

12. Severity of symptoms: ___ mild ___ moderate ___ significant ___ other
(please explain below)

(I) Description of the student's functional limitations or behavioral manifestations in a college residence hall setting:

(J) MEDICAL PROVIDER COMMENTS: Please list your specific recommendations for reasonable housing accommodations for this student in a college residence hall

Signature of Physician/Medical Care Provider: _____ Date: _____

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