

Disability-Related Housing Accommodation Request Form

To properly evaluate how to meet the student's need for reasonable accommodations in campus housing, Lincoln College requires specific information from the diagnosing clinical or health care professional. The person providing that diagnostic information should be a current licensed clinical or health care provider to the student and be familiar with the history and functional limitations of the student's physical or psychological condition(s). The provider should not be a close relative of the student.

<u>Section A</u> must be completed by the student and returned to the Director of Residence Life.

<u>Section B</u> should be signed by the student and then completed by the diagnosing/treating professional who should return the form to the Office for Disability Services. The student's signature authorizes the appropriate Lincoln College representative to communicate with the provider who completes **Section B** of the form.

<u>Section C</u> and <u>Section D</u> are required only for requests related to an emotional support animal (ESA) in College housing. **Section C** should be completed by the diagnosing/treating professional and **Section D** should be completed by the student and a veterinarian familiar with the animal.

Section A

(to be completed by the student and submitted to the Director of Residence Life)

Student Information Name: LC Student ID: Session for which accommodation is requested □Fall □ Spring Summer Accommodation(s) Requested ☐ Emergency Alert System ☐ Single Room ☐ Other (explain) ☐ Air Conditioning ☐ Semi-Private Bath ☐ Wheelchair Accessibility ☐ Dietary Consult Residential Life Signature Signature of Residential Life Director ______

Section B



(to be completed by the clinical or health care professional and returned to the Office for Disability Services)

A patient/client of yours has requested disability-related housing accommodations at Lincoln College. As this student's treating specialist, you are asked to provide the following information to allow the College to consider this student's request(s). **Information you provide is considered by law to be protected by the Family Educational Rights and Privacy Act.** As such, the student has a legal right to view the document.

Authorization to Receive Medical Information

I authorize Lincoln College to receive information from the licensed clinical or health care provider identified below. I also authorize my provider to discuss my condition(s) with representatives from the Office for Disability Services on an as-needed basis as it relates to my housing request.

to my h	ousing request.
Studen	: Signature Date
Descri	ption of the functional impact of the student's condition
1.	Is the student currently under your care?
2.	When did you last see the student?
3.	What is the diagnosis/impairment?
4.	Is the impairment ☐ temporary (< 3months) or ☐ persistent?
5.	How long has the student had the condition?
6.	Please identify factors that may affect the severity of the impairment (e.g., to what degree might the impairment be minimized by medications, hearing aids, etc.) alternatively, could there be an adverse effect (e.g., medication side effect)?
7.	Are the functional limitations current (affecting the student now) or potential (student has been affected in the past and/o may be in the future)? Please explain.

8. Please complete the following functional impact assessment. 3 – Substantial 2 – Mild 1 – Unable to Determine

1	2	3	Major Life Activity
			Caring for oneself
			Talking
			Hearing
			Breathing
			Seeing
			Walking/Standing
			Lifting/Carrying
			Sitting
			Performing Manual Tasks
			Eating
			Working
			Interacting with Others
			Sleeping
			Thinking
			Major Bodily Functions

2	3	Learning
		Reading
		Writing
		Spelling
		Calculating
		Concentrating
		Memorizing
		Listening
		Communicating
		Other (Please Explain)
	2	2 3

10.	Describe how the student's conditi	on necessitates the need for a housing accommodation. Please state specific					
	recommendations regarding housing accommodations and a rationale as to why these housing needs are warranted based on the student's medical (physical/emotional health) condition (for example, if you suggest a semi-private bathroom, state the reasons for this request related to the student's condition). Attach additional sheets if necessary.						
	Recommendation	Rationale					
	Recommendation	Kationale					
	L						

9. Use the space below to describe the symptoms related to the student's condition that cause substantial impairment to a major life activity (could include side effects of medication if relevant). Attach additional sheets if necessary.

Symptoms

Provider Information

Professional Signature:			
Agency Name:			
Title:			
License #:		_	
Date:			
Street Address:	City	_ State	Zip
Email:			
Phone:	Fax:		_

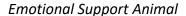
I verify that the information about the above-named student is correct and that the student is a patient I have been treating.

Thank you for taking the time to complete this form. If we need additional information, we may contact you at a later date. Please return this form to the Office for Disability Services at Lincoln College.

Office for Disability Services Lower Level, Harts Science Building Lincoln College 300 Keokuk Street Lincoln, IL 62656 Email: ods@lincolncollege.edu

PHONE: 217.735.7335 FAX: 217.735.4902

Section C





(To be completed by the clinical health care professional and returned to the Office for Disability Services. The health care provider need not use this specific form, but all the information requested here is necessary for the institution to have in order to consider the request for an ESA; the form is provided as a convenience.)

STUDENT: Please sign this form before providing it to your mental health provider to complete.

By signing below, I consent to allow my health care provider to share any information relevant to my need for an ESA as an accommodation, as shown with this form, with the Office for Disability Services at Lincoln College for the next 60 days.

Signature	Date			
Student's Name:				
Name of Proposed ESA (if available):				
Type of animal:	Age of animal:	years months		
The above-named student has indicated that you are the treating clinical professional who has suggested that having an Emotional Support Animal (ESA) in the residence hall will have therapeutic benefit in alleviating one or more of the identified symptoms or effects of the student's mental health disability. Generally, Lincoln College will accept documentation from providers in the State of Illinois or from the students' home state who have personal knowledge of the student, consistent with their professional obligations. Providers should not be related to the student. The student has signed this form (above) indicating written permission to share additional information with the Office for Disability Services in support of the request. To allow us to better evaluate the request for this accommodation, please answer the following questions: Information about the student's disability (Federal law defines a person with a disability as someone who has "a physical or mental impairment that substantially limits one or more major life activities," which suggests that a diagnosis does not necessarily equate with a disability (substantial limitation).				
1. Describe the nature of the student's				
2. Does the student require ongoing tr	reatment? \square Yes \square	□ No		
3. When did you first meet with the stu	3. When did you first meet with the student regarding this mental health diagnosis?			
4. When did you last interact with the	student regarding this mental health	h diagnosis?		

Information about the Proposed ESA

(Please note that there are some restrictions on the kind of animal that can be approved for the residence hall; it is possible that the student may be approved for an ESA, based on the information you provide here, but may not be allowed to bring the specific animal named.)

1.	Is the animal named here one that you specifically prescribed as part of treatment for the student (i.e. not a pet), or is it a pet that you believe will have a beneficial effect for the student while in residence on campus?				
2.	What specific symptoms will be reduced by having the ESA and how will those symptoms be mitigated by the presence of the ESA?				
3.	Is there evidence that an ESA has helped this student in the past or currently? \Box Yes \Box No				
4.	Is there evidence that an ESA has helped this student in the past or currently? \Box Yes \Box No				
mportance of ESA to Student's Well-Being					
1.	In your opinion, how important is it for the student's well-being that the ESA be in residence on campus?				
2.	What consequences, in terms of disability symptomology, may result if the accommodation is <u>not</u> approved?				
3.	Have you discussed the responsibilities associated with properly caring for an animal while engaged in typical college activities and residing in campus housing? (If you and the student have not had this conversation, we will discuss this with the student at a later date.) \[\textsqr{Yes}\] \[\textsqr{No}\]				
4.	Do you believe those responsibilities might exacerbate the student's symptoms in any way? \Box Yes \Box No				

Thank you for taking the time to complete this form. If we need additional information, we may contact you at a later date. The named student has signed the front page of this form indicating written permission to share additional information with the Office for Disability Services in support of the request. We recognize that having an ESA in the residence hall can be a real benefit for someone with a significant mental health disorder, but the practical limitations of our housing arrangements make it necessary to carefully consider the impact of the request for an ESA on both the student and the campus community.

Please provide contact information, sign and date this form (below), and return it to the Office for Disability Services at Lincoln College.

Email: ods@lincolncollege.edu

PHONE: 217.735.7335

Office for Disability Services Lower Level, Harts Science Building Lincoln College 300 Keokuk Street Lincoln, IL 62656

300 Keokuk Street FAX: 217.735.4902

Prescriber Information

Professional Signature:			
License #:		_	
Date:			
Street Address:	City	State	Zip
Email:			
Phone:	Fax:		-

Section D

Lincoln College Office for Disability Services ESA Emergency Contact Form and Animal Health Certification

(to be completed by the student and returned to the Office for Disability Services)

The student must identify an individual not residing in College housing who agrees to act as an emergency contact in the event that the student is unable to care for the animal due to an emergency. Please indicate the designated emergency contact below:

Emergency Contact Information:

Name:		_
Relationship to Owner:		
Street Address:	City	State Zip
Email:		
Phone:		
The student must supply evidence from a veterinarian licensing requirements, and is immunized for diseases a satisfied by having your veterinarian complete the loweveterinarian.	common to the particular species	s. That requirement may be thing records supplied by the
To be completed by the veterinary office personnel		
Animal Name:		
Date of Examination:		-
At last examination, the animal appeared to be in goo	od health:	□no
The animal is current in required vaccinations:	□Yes □no	
Animal's Breed/Type	Animal's Weight:	
Veterinarian's license number and state of licensure		
Email:		
Phone:	Fax:	
Veterinarian Signature:		
Date:		