Evangel University

VERIFICATION OF A DISABILITY AND ACCOMMODATION REQUEST BY A MENTAL HEALTH CARE PROVIDER OR MEDICAL HEALTH CARE PROVIDER

Housing Accommodation

Purpose: This completed questionnaire will provide the Housing Office with information to evaluate an accommodation request for a special accommodation in University Housing.

Mental Health Disability: The attached form must be completed by the student's psychiatrist, psychologist, or relevantly trained and licensed mental health care provider.

Physical Disability: The attached form must be completed the student's doctor or licensed medical health care provider.

The provider(s) may, as an alternative, write a letter or report that addresses all questions included in this form. The best way to ensure inclusion of all required information is to complete the form and add any additional supporting information in a letter on official letterhead. **All documentation must be mailed from the mental health care provider directly to the Housing Office (not to the student) listed at the end of this form.**

Interactive Accommodation Process: The legal definition of a disability includes **two elements**: (1) a physical or mental impairment that (2) substantially limits one or more of the major life activities of the person in question. Thus, disability has both diagnostic and functional elements, and **BOTH elements must be documented for effective determination.**

Housing Accommodation
Documentation Information Form

Student Contact Information (Student completes this section)

Student's Name: _____ Date of Birth: _____

Phone Number: _____ Student Identification Number: _____

Student's requested accommodation is for the following term:

☐ Fall _____ ☐ Spring _____ ☐ Summer _____

Instructions for the provider:

Please ensure you are the correct provider to fill out this form. Are you completing this form for a mental health or a physical disability? _____

Your name, signature, title, and credentials must be provided on this form. [Please note: Section 1001 of Title 18 of the United States Code makes it a criminal offense to willfully falsify a material fact or make a false statement in any matter within the jurisdiction of a federal agency]. Please answer the questions as thoroughly as possible.

Provider Information

Name: _____Title: _____

Phone Number: _____

License or Certification Number: _____ Expiration Date: _____

Are you the student's medical or mental health provider? _____

Signature: _____

Date: _____

Please provide answers to the following questions, keeping in mind that Federal laws define a person with a disability as, "any person who has a physical or mental impairment that substantially limits one or more major life activities; has a record of such impairment; or is regarded as having such an impairment."

Does the student listed above have a physical or mental impairment that substantially limits one or more major life activities including, but not limited to: caring for oneself, performing manual tasks, seeing, hearing, eating, sleeping, walking, standing, lifting, bending, speaking, breathing, learning, reading, concentrating, thinking, communicating, and working?

☐ Yes ☐ No

1. Diagnosis: (DSM-V)_____

   Severity level (indicate for each diagnosis if more than one) _____
   _____
   _____
   _____

   Date of diagnosis: _____
   Date first seen: _____
   Number of visits: _____

1. Please summarize relevant history and/or observations (i.e., how is the student substantially limited in the housing environment by this diagnosis).

2. Does this student require ongoing treatment? Please explain.

3. Explain the proposed Housing Accommodation and note this is recommended or specifically prescribed by you as part of an ongoing treatment plan?

4. Is the proposed Housing Accommodation one that will have a beneficial effect for the student while residing in EU housing? Please explain.

5. What disability symptoms will be reduced by the Housing accommodation?

6. What evidence exists that the proposed Housing Accommodation will reduce the impact of the student's disability in the living environment (currently or in the past)?

7. In your professional opinion, will the Housing accommodation alleviate one or more of the identified symptoms or the effects of the student's existing disability? What would the impact(s) be, in terms of disability symptoms, that may result if the Housing Accommodation is **not** allowed?

8. Is there a different/another accommodation that could be provided in the living environment to meet this student's needs? If so, please describe below.

9. Is there any additional information that you would like to share?

Return this form to:

Danielle Poulson-Jones
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Evangel University
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Springfield MO 65802
FAX: 417-965-9599
Email: poulsonjonesd@evangel.edu