



Disability – Related Housing Accommodation Request Provider Verification

Student Name: _____

Dear healthcare provider:

In accordance with Section 504 of the Rehabilitation Act of 1973 and the Americans with Disabilities Act (ADA), Concordia University, Nebraska recognizes the importance of providing reasonable accommodations in its housing policies and practices where necessary for individuals with disabilities to have full access to the benefits of University housing. The obligation of the University is to provide access for all students in a safe and supportive living environment, and the University is generally able to accommodate medical/disability needs through on-campus housing.

To determine eligibility for accommodations to the housing environment, Concordia University requires current and comprehensive documentation of the student's disability from an appropriate licensed professional or healthcare provider who can verify that the individual has a disability and that the requested accommodation is necessary to provide the individual with a disability to have full access to the benefits of University housing. This person must be someone who is familiar with the history and functional limitations of the individual's disability, including the impact on major life activities, and the necessity for the requested accommodation. Generally, someone related to the student should not be the one to provide supporting documentation.

The answers to the following questions are important in our decision-making and the documentation provided that supports the student's request should address these questions as thoroughly as possible. Providers may choose to address these questions through a detailed letter that is on professional letterhead, typed, signed, and dated. A prescription form, brief description, or brief memo/letter is not sufficient information for our review process.

All medical/disability-related accommodation decisions will be made in the context of University policies applicable to the individual making the request. Documentation supporting a request will be reviewed by the Disability Support Services Office and the Housing Committee, as appropriate. All information is considered confidential.

Please understand that submission of this information does not guarantee that a specific housing accommodation will be provided.

(To be completed by the student's health care provider)

Provider, please include your

- name,
- title,
- your signature,
- licenses
- **and** include answers to at least the following questions:

1. How long has this student been your patient?
2. When was the student's last scheduled visit with you?
3. Please state the names of the student's specific medical/psychological condition/ diagnosis (you may include DSM-V or ICD-10 codes):
4. How long has the student had this diagnosis?
5. What is the severity of this condition?
_____ Mild _____ Moderate _____ Severe

Under Section 504 of the Rehabilitation Act, a person is considered to have a disability if that person:

- *Has a physical or mental impairment that substantially limits one or more of such person's major life activities,*
- *Has a record of such an impairment, or*
- *Is regarded as having such an impairment.*

6. Based on this definition, in your professional opinion, does the student have a disability?
_____ Yes _____ No
7. Is the student's disability permanent, temporary or episodic?

8. Does the condition substantially limit a major life activity? _____ If yes, please explain in detail the functional impact of the limitation in a housing setting. What barriers does the student encounter?

9. If applicable, please describe the relevant history of remediation (e.g., current medications, side effects of medications, other treatment plans and their effectiveness, etc.).

10. What adaptations or recommendations are necessary for safe and independent occupancy in a living environment?

11. What is the impact on the student if the recommendation is not met?

12. What kind of support, services, and environment does the student need in order to access and participate in their studies, job, community, etc.?

I authorize Concordia University, Nebraska to receive information from the provider listed below. I also authorize my provider to discuss my situation with the appropriate University personnel in order to make a proper determination of necessary accommodations, if appropriate. My signature also indicates that the statements and documentation have been provided by me.

This also acts as a release of content form for all relevant parties, including those on the Housing Accommodations Committee and other campus professionals, who may be involved in determining housing accommodations or acting in an advisory capacity.

Provider Name: _____

Provider Phone: _____

Provider Address: _____

Fax: _____

I understand that providing false or misleading information is in violation of the Concordia University, Nebraska Student Code of Conduct and subjects me to any applicable sanctions.

I understand that submission of this information does not guarantee that a specific accommodation will be granted.

Student name (printed) _____

DOB _____

Student Signature: _____ Date: _____

Please submit to:

Disability Support Services
Concordia University
Link - 143
800 N. Columbia Ave.
Seward, NE 68434
Phone: 402-643-7187
Fax: 402-643-4218
ada@cune.edu