Request for Housing due to Medical Issues

The following guidelines have been established to accommodate students who have special needs that may impact their housing.

Policy Statement:
All requests will be reviewed on a case-by-case basis and documentation of a special need or disability does not guarantee that your application will be approved. Assignments are made only if space is available. Assignment to a specific residence area cannot be guaranteed. Learning disabilities, attention deficit disorder, and most psychological disorders generally do not warrant special housing. All requests will be reviewed by the Director of Health Services and by the Director of Housing and Residential Life on a case-by-case basis. It should be noted that medical requests are for an individual, not a group. The Office of Housing and Residential Life makes all final decisions for medical requests.

Procedure:
1. Complete the attached form.
2. Submit forms with supporting documentation to the Office of Housing and Residential Life in Rotunda 387.
3. Students need to re-apply each year and submit updated supporting documentation as necessary.

If you have any questions regarding this policy, please contact the Office of Housing and Residential Life at (845) 575-3307.

Continuing Resident Students must complete the form below and submit the completed form to the Office of Housing and Residential Life prior to May 1, 2014

Incoming Resident Freshmen Students must complete the form below and submit the completed form to the Office of Housing and Residential Life prior to June 20, 2014

Name: __________________________________________ CWID #: _________________________
Campus Address: _________________________________ Cellular Phone: ______________________
Home Address: _________________________________ Home Phone: ______________________
Diagnostician Form

Student Name: __________________________

Submit the following form to the diagnostician who performed your original evaluation (if available) or a comparable source. The diagnostician must be an impartial individual who is not a family member nor in a dual relationship with the student.

Diagnostician Name: ___________________ Phone Number: ________________

Diagnostician Signature: __________________ Date: ________________

Professional License Number: __________________ Email: ________________

Please provide the following information regarding the above named student’s request for special housing accommodations at Marist College. It should be forwarded on letterhead to the appropriate office listed below along with this form.

• A copy of the most recent evaluation.
• The current impact of (or limitations imposed by) the condition
• Treatments, medications, devices or services currently prescribed or used to minimize the impact of the condition
• The expected duration, stability or progression of the condition
• A clear connection between the recommended housing arrangement to the impact of the condition.
• A statement of the level of need for (or consequences of not receiving) the recommended configuration
• A clear description of the recommended housing arrangement

Office of Housing and Residential Life
Marist College
3399 North Road
Poughkeepsie NY, 12601
Telephone: (845) 575-3307
Fax: (845) 575-3788
Special Housing Accommodations for Health/Medical Concerns

Please have your primary care provider fill out this form to be considered for special housing.

Student Name _____________________________________ Date ______________________________

Diagnosis __________________________________________________________________________

Medications __________________________________________________________________________

Last hospitalization for this diagnosis ______________________________________________________

Last exacerbation of this diagnosis ________________________________________________________

Treatment plan _______________________________________________________________________

Accommodations needed:
_ Air Conditioning  _ Handicapped Accessible
_ Single Space         _ Handicapped Bathroom
_ Other (Specify) _______________________________________________________________

Duration accommodations required _______________________________________________________

Role Accommodations will play in treatment plan ____________________________________________

___________________________________________________________________________________
___________________________________________________________________________________
___________________________________________________________________________________

Health Care Provider Signature __________________________________________________________
Print Name __________________________________________________________________________
Address _____________________________________________________________________________
Telephone ___________________________________________________________________________

This form will be reviewed by the Director of Office of Housing and Residential Life and the Director of Health Services. By submitting this form, the student is giving the Director of Health Services permission to contact her/his primary care provider for further information, if necessary.

Student Signature __________________________________ Date ______________________________

Please submit this form to:
Office of Housing and Residential Life
Marist College
3399 North Road
Poughkeepsie, NY, 12601
Or Fax to (845) 575-3788
Request for College Housing due to Psychological/Psychiatric Disability Needs

*Please have your treating professional fill out this form to be considered for special housing.*

Student Name_____________________________________ Date form completed __________________

Name of person completing this form______________________________________________________

Professional credentials _____________________________ Title ______________________________

Address _____________________________________________________________________________

Telephone ___________________________________________________________________________

Role of person completing form: □ treating professional □ evaluator
□ other _____________________________________________________________

Date of first contact (d/m/y, if possible) _________________________________________________

Frequency of continuing contact with student: □ none □ weekly
□ other (explain) ___________________________________________________________________

___________________________________________________________________________________

___________________________________________________________________________________

___________________________________________________________________________________

___________________________________________________________________________________

Is the student in treatment? □ yes □ no □ no information

Is the student on medication? □ yes □ no □ no information

If yes, what medication(s) _______________________________________________________________

___________________________________________________________________________________

___________________________________________________________________________________

___________________________________________________________________________________

What is the date of your most recent contact with the student? ______________________________

Is the student compliant with treatment? □ yes □ no □ no information

Does the treatment mitigate some of the functional limits caused by the student’s impairment?

□ yes □ no □ no information

How long do you expect that this student will be in treatment? ______________________________

___________________________________________________________________________________

___________________________________________________________________________________

___________________________________________________________________________________

Describe the continuing treatment plan: ___________________________________________________
What accommodations do you recommend?

___________________________________________________________________________________
___________________________________________________________________________________
___________________________________________________________________________________
___________________________________________________________________________________
___________________________________________________________________________________

Detail any relevant history regarding how these or other accommodations have affected this student in similar settings or how you anticipate that the accommodations will affect the student in this setting:

___________________________________________________________________________________
___________________________________________________________________________________
___________________________________________________________________________________
___________________________________________________________________________________
___________________________________________________________________________________

Functional Limitations: (Please feel free to use additional pages for comments) Describe the student’s functional limitations that significantly impair a major life activity (i.e., learning, thinking, concentrating, interacting with others, caring for oneself, speaking, performing a Manual task, sleeping or working).

___________________________________________________________________________________
___________________________________________________________________________________
___________________________________________________________________________________
___________________________________________________________________________________
___________________________________________________________________________________

Please submit this form to:

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Marist College
3399 North Road
Poughkeepsie, NY, 12601
Or Fax to (845) 575-3788