**UWW CSD Room Modification Assessment Form**

**Introduction:**

The Center for Students with Disabilities provides academic services and accommodations for students with diagnosed disabilities. Students are required to provide documentation that verifies that a diagnosed disorder meets the legal definition of a disability covered under Section 504 of the Rehabilitation Act of 1973 and Title II of the Americans with Disabilities Act (ADA) of 1990. These laws define a disability as a physical or mental impairment that substantially limits one or more major life activities. In addition, eligibility for academic accommodations is based on the data in the documentation that clearly demonstrates that a student has one or more functional limitations in the campus housing setting and that these limitations require accommodation in order to achieve equal access. Accommodations are intended to be outcome neutral. Demonstrating improved performance with an accommodation, in and of itself, is not evidence that a person has a disability.

**Documentation Requirements:**

Current and comprehensive documentation of a medical condition or disability is required in order to determine appropriate services and room accommodations, including (but not limited to) the use of air conditioners, single rooms, or living off campus due to medical reasons.

**Guidelines for Completing the CSD Room Modification Assessment Form**:

The information below will assist the student with a diagnosed medical condition in working with the treating or diagnosing healthcare professional to obtain specific information necessary to evaluate eligibility for academic accommodations.

**A. The student requesting accommodations should complete the questionnaire regarding the need for the requested accommodation(s).** Housing accommodation requests *must* be relevant to the student’s housing/living, not academic, needs (e.g. sleeping). For example, students with ADHD who request a private room in order to have a quiet study area can have that need met through use of the libraries and other spaces around campus that are suitable for quiet study.

**B. The healthcare professional conducting the assessment and/or making the diagnosis must be qualified to do so.** This includes professionals who have undergone comprehensive training and have relevant experience in diagnosis of (e.g. Allergist, M.D., Psychologist, etc. ).

**C. All parts of the Room Modification Assessment Form must be completed as thoroughly as possible by the student and qualified healthcare professional as indicated.** Inadequate information, incomplete answers and/or illegible handwriting will delay the eligibility review process and require follow up contact for clarification.

**D. The qualified healthcare provider should attach any reports which provide additional related information** (e.g. lung capacity/function, a letter stating specific relevant information not listed below etc.).

**E. After filling out the Room Modification Assessment form, e-mail or fax the completed form to the Center for Students with Disabilities (fax: 262-472-4865;** [**csdat@uww.edu**](mailto:csdat@uww.edu)**).** All disability information you provide will *not* become part of the student’s educational records. It will be kept in the student’s file at CSD, where it will be held strictly confidential. This form may be released to the student at his/her request. In addition to the requested information, please attach any other information relevant to the student’s academic adjustment.

## **Information Regarding the Proposed Accommodation(s)** (completed by student)**:**

|  |  |
| --- | --- |
| What accommodation(s) are you requesting? What is/are the disability/ies necessitating this accommodation? |  |
| What symptoms/limitations require the housing accommodation(s)? |  |
| In what ways will this accommodation alleviate one or more of the identified symptoms/limitations? |  |
| Have you had difficulties in living spaces due to your disability? If so, please explain. |  |
| What treatments or management strategies have been tried before/are you currently utilizing? What role will the housing accommodations play in your overall well-being? |  |

**CSD Room Modification Assessment Form**

**This form is to be completed by a QUALIFIED HEALTHCARE PROFESSIONAL**

**Student/Client Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**DIAGNOSTIC INFORMATION**

1. Diagnosis/es:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2. Student’s Current Symptoms and Severity**:**

Provide **specific** examples of **current** symptoms/functional limitations that have been **reported by the student** such as medications, increased need for medical treatment for secondary infections, etc. and describe their **severity**.

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3. Approximate date of initial diagnosis: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

4. Current treatment plan:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

5. Please state **specific accommodation recommendations** for this student and a **rationale** as to why the accommodation is necessary:

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\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| **6. Please complete the following by comparing patient/student to same age peers in the context of post-secondary education. For example, a rating of 2 would indicate that symptoms impact a major life activity on a regular basis and in a significant manner, while a rating of 1 indicates occasional impact that is modestly disruptive.**    **FUNCTIONAL IMPACT ASSESSMENT**  **IMPACT IS: ? = Unknown 0 =None 1 = Mild/Moderate 2 = Substantial/Severe**   |  |  |  |  |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | | **?** | **0** | **1** | **2** | Major Life Activity |  | **?** | **0** | **1** | **2** | Major Life Activity | |  |  |  |  | Caring for oneself |  |  |  |  | Learning | |  |  |  |  | **Talking** |  |  |  |  | * **Reading** | |  |  |  |  | **Hearing** |  |  |  |  | * **Writing** | |  |  |  |  | **Breathing** |  |  |  |  | * **Spelling** | |  |  |  |  | **Seeing – Close distance** |  |  |  |  | * **Calculating** | |  |  |  |  | **Seeing – Long distance** |  |  |  |  | * **Concentrating** | |  |  |  |  | **Lifting/Carrying** |  |  |  |  | * **Memorizing** | |  |  |  |  | **Sitting** |  |  |  |  | * **Listening** | |  |  |  |  | **Performing Manual Tasks** |  |  |  |  | * **Speaking** | |  |  |  |  | **Eating** |  |  |  |  | **Other:** | |  |  |  |  | **Working** |  |  |  |  | **Other:** | |  |  |  |  | **Interacting with Others** |  |  |  |  | **Other:** | |  |  |  |  | **Sleeping** |  |  |  |  | **Other:** | |  |  |  |  | **Walking/Standing** |  |  |  |  | **Other:** | |

**7. Certifier Information/Credentials**

|  |  |  |  |
| --- | --- | --- | --- |
| **Name:** | | **Date:** | |
| **Medical Specialty:** | | | **License #:** |
| **Address:** | | | |
| **Phone:** | **Email:** | | |
| **Clinician’s Signature:** | | | **Printed Name:** |

Please mail or fax this completed form and any additional information to:

Center for Students with Disabilities

800 W. Main St.

2002 Andersen Library

Whitewater, WI 53190

(262) 472-4711 (voice, tty, relay)

(262) 472-4865 (fax)

If you have questions, please feel free to contact our office. Thank you.