Rhode Island College Disability Services Center, 600 Mt. Pleasant Ave. Providence, RI 02908
Phone: (401)-456-2776 Fax (401)-456-9525

Request for Reasonable Housing Accommodations Application

INSTRUCTIONS TO STUDENT: The **student** will complete **Part I** of this form. The student's **healthcare provider** will complete the Certification of Disability form, **Part II**. The **student** must sign the Authorization for Release of Information, **Part III**, and submit the completed application with all supporting documentation to the Disability Services Center for review by the Reasonable Housing Accommodations Committee. All information provided is kept confidential under applicable laws and will only be shared with the necessary committee professionals to fully evaluate the request. This is a 5 page application. Please make sure you return all pages.

Part I. REQUEST FOR REASONABLE HOUSING ACCOMMODATIONS

PLEASE NOTE: This process and all related disability documentation are specific to HOUSING accommodation requests only. To request academic accommodations, you must complete the Disability Services Center registration process. Please visit our website at www.ric.edu/disabilityservices, e-mail dsc@ric.edu, or call 401-456-2776 for more information.

Name: _____

Date of Birth_____ RIC ID# (if known):_____

Phone: _____ Student E-Mail _____

Semester(s)/ Academic Year for which accommodation is requested:

_____

Current RIC housing assignment (if any):

_____

Please indicate Class Year: ___Freshman ____Sophomore ___Junior ___Senior ___Transfer

Have you previously applied for disability housing accommodations at RIC? ____YES ____NO

If yes, when? _____If yes, please list any accommodations that you received:

_____

I am requesting the following housing accommodations: (Requested accommodation must be clearly linked to functional limitations. A specific building or roommate request is not considered a reasonable accommodation and will not be evaluated as such).

Please check all that apply:

- ☐ Single Room (Note: All upperclassmen at RIC are automatically eligible for a single room. If you are an upperclassman and a single room is your only request, you do not need this form.)
- ☐ Semi-Private Bathroom (Note: There are no fully private bathrooms in RIC residence halls.)
- ☐ Low Occupancy (Double Room)
- ☐ Air Conditioning
- ☐ No Carpet
- ☐ Ground Level Room
- ☐ Flashing Alarm
- ☐ Wheelchair Accessible Unit (please specify what modifications you need, i.e. grab bars roll-in shower, etc.)

  _____
  _____
  _____
  _____

- ☐ Other:_____

  _____
  _____

Do you require evacuation assistance: _____Yes _____ No

If yes, please describe your needs for evacuation assistance:

_____
_____
_____
_____

Please sign below, indicating that you have read the Informational Packet provided to you with this application

_____

Name Date

Part II. CERTIFICATION OF DISABILITY

Health Care Provider: Please respond to the following questions regarding the above named student.

To the Student: THIS FORM MUST BE FILLED OUT IN ITS ENTIRETY BY YOUR CLINICIAN. If this form is completed by anyone other than a qualified licensed professional, the information provided may not be used to support your accommodation request and the Disability Services Center reserves the right to request additional documentation. Since a request for additional information can result in a delay in your request for accommodations, you are strongly urged to have the form completed by a qualified clinician who will include all requested information.

To the Evaluator: The student named has represented that s/he has a disability which will require a housing accommodation at Rhode Island College. The information you provide will be used to determine the appropriateness of the requested accommodations. **Please take the time to complete this form and thoroughly answer all questions.** You may fax us a copy, but our records must include an original with your signature. We cannot accept substitutions for this form but you may provide supplemental information on official letterhead. Please contact us with any questions. All information provided to us is confidential. With the student's permission, we may contact you directly for additional information to assist us in making a determination.

Student Name: _____

1. Please provide the DSM IV and/or the ICD-9 codes for the condition(s) for which the housing accommodations requested:

_____
_____
_____
_____

2. Please list date of onset and severity:

_____
_____
_____
_____
_____

3. How long have you been treating the individual?

_____

_____

4. When was the last visit you had with the individual?

_____

5. Please list any current functional issues and impact on activities of daily living <u>in residence halls</u>:

_____

_____

_____

_____

_____

6. What is the current treatment plan (including medications)?

_____

_____

_____

_____

_____

7. Please provide the results and dates of any testing and/or evaluations used to determine diagnosis and past treatment and response.

_____

_____

_____

_____

_____

Healthcare Professional Name:

_____

Professional Licensure: State_____ Number_____

Healthcare Professional Signature: _____

Date: _____

Office Address: _____

Office Phone: _____

Part III. AUTHORIZATION FOR RELEASE OF INFORMATION

I, _____,
(Student Name)
hereby authorize the following individuals and/or organizations to release all treatment records, relevant tests and case summaries in their possession regarding me to the Rhode Island College Disability Services Center's Housing Committee and for the Disability Services Center (DSC) to discuss such information in its possession to the individual and/or organizations listed below:

Name of individual and/or organizations who will release or receive information:

_____

_____

This authorization allows the above individuals and/or organizations to copy and send records to the DSC and allows representatives of DSC to review the records. This authorization allows the above individuals and/or organizations to discuss my condition and needs with the DSC staff. This authorization encompasses all records pertaining to my condition, including "third party records" created by any other individuals or organizations. Pursuant to HIPAA, the following are specified as part of this authorization:

The purpose of disclosure is to assist Rhode Island College in determining whether I have a disability as defined by the Americans with Disabilities Act and what accommodations may be appropriate. This authorization expires one year after the date it is signed.

I understand that I have the right to revoke this authorization at any time by providing written notification to Rhode Island College or the individuals and organizations listed above, and that revoking this authorization does not apply to information that has already been released by this authorization.

I have been informed that the individuals and organizations listed above may not condition treatment, payment on whether I sign this authorization.

I have been informed that the information disclosed may be re-disclosed if the recipient(s) of this information is not required by law to protect the privacy of the information, and the information is no longer protected by HIPAA privacy rules. I am also aware that any information disclosed to Rhode Island College is subject to other state and federal privacy laws.

Student Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____
(***Only if student is under age 18***)