

## HOUSING DOCUMENTATION FORM

Dear Medical/Clinical Provider:

The below-named student has requested housing accommodations from the office of Disability, Access, and Inclusion (DAI) at the University of Rhode Island. **By providing a full and complete response, you will help to expedite the processing of this student's accommodation request, and reduce the need to return to you for additional information.**

Under the Americans with Disabilities Act (Amendments Act) of 1990 (2008) and Section 504 of the Rehabilitation Act of 1973, otherwise qualified individuals with disabilities are protected from discrimination and may be entitled to reasonable accommodations. To establish that an individual is protected under the law, documentation must indicate that a *specific disability exists* and that the identified disability *substantially limits one or more major life activities*, and impacts a student's *living environment* in such a manner that accommodations are medically necessary.

All contact information and documentation provided to this office is kept in a secure, encrypted server accessible only to DAI personnel and vetted IT professionals with a technological need for access. Information concerning accommodations or documentation will not be released or discussed without written consent from the student.

**All sections of this form must be completed** and returned as soon as possible so that we may verify eligibility. Providers may also use their own format as long as the requested information is included, and the letter meets the documentation guidelines posted on our website (see footer). Incomplete or illegible requests may be returned, which will delay processing. This form and any other relevant documentation may be faxed to 401-874-5694 or emailed to [dai@uri.edu](mailto:dai@uri.edu).

Thank you in advance for your time and support.

The DAI Team

Student's Name: \_\_\_\_\_

Date of Request: \_\_\_\_\_

**Student Information - Completed by the Provider ONLY**

First Name \_\_\_\_\_ Middle \_\_\_\_\_ Last \_\_\_\_\_

Date of Birth \_\_\_\_\_

**Diagnostic Information**

Primary Diagnosis \_\_\_\_\_ Date of Diagnosis \_\_\_\_\_

Secondary Diagnosis \_\_\_\_\_ Date of Diagnosis \_\_\_\_\_

How was the diagnosis made? (please check all applicable answers)

- |  |   |
|--|---|
| <input type="checkbox"/> Interviews with the person themselves | <input type="checkbox"/> Testing ( <b>please enclose a copy</b> ) |
| <input type="checkbox"/> Interviews with other persons         | <input type="checkbox"/> Neuro-Psychological Testing              |
| <input type="checkbox"/> Behavioral Observations               | <input type="checkbox"/> Educational Testing                      |
| <input type="checkbox"/> Developmental History                 | <input type="checkbox"/> Psychological Testing                    |
| <input type="checkbox"/> Educational History                   | <input type="checkbox"/> Other (please specify) _____             |

Please indicate the level of need for the accommodations listed below. **Further detail is required on the next page.**

Housing Accommodations	Minimal /None	Moderate/ Preference	Medically Necessary	Unsure
First floor room				
Private/semi-private room (specify on next page)				
Private/semi-private bathroom (specify on next page)				
Ability to control room temperature				
Personal refrigerator for medication storage.				
Auditory/Visual safety alarms (specify on next page)				
Personal Refrigerator				
Proximity to Dining, Health Services, etc...				
Height adjusted room furniture				
Service/Emotional Support Animal				
Early Move-in				
Safety support/alert to first responders				
On campus housing as reasonable accommodation				
Other: _____				
Other: _____				

**Medically Necessary Accommodations**

Please provide a detailed explanation of the medically necessary accommodations from the previous section.

Medically necessary accommodation title:	
Medically necessary accommodation title:	
Medically necessary accommodation title:	
Medically necessary accommodation title:	
Medically necessary accommodation title:	

Please use the space below to list additional accommodations, and/or pertinent information. You may provide a separate letter or document detailing the information if there is not enough space in this form to do so.

**Certifying Medical Professional**

\_\_\_\_\_  
 Signature of Medical Professional (required)

\_\_\_\_\_  
 Date

License # \_\_\_\_\_

\_\_\_\_\_  
 Printed Name and Title

Phone # \_\_\_\_\_