

## Request for Special Needs Housing

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### Office of Residence Life

Mount St. Mary's University  
(301) 447-5274 Fax: (301) 447-5818

Dear Student,

In an effort to effectively respond to student requests for special housing modifications or accommodations, Mount St. Mary's University has created a process to help better serve our students. A group of professionals representing Learning Services, University Health Services and the Office of Residence Life will evaluate all requests and make the appropriate decisions.

In order to fully evaluate your request, the Office of Residence Life, will need documentation of your condition or disability. Documentation should be current and comprehensive in light of the request and must consist of an evaluation by an appropriate professional that describes the current functional impact of the condition or disability as it relates to the housing modification or accommodation requested.

Documentation provided will be used by Residence Life to evaluate your request. Residence Life will generate a list of potentially reasonable modifications or accommodations based on:

- Preferences of the diagnosing professional
- Potential effectiveness
- Maximum level of integration
- Potential for an undue financial or administrative burden

Mount St Mary's University reserves the right to request additional documentation if the information submitted appears to be outdated, inadequate in scope, or content, does not address the student's current level of functioning or substantiate their need for modifications or accommodations. Students will be notified in writing of the decision.

### **Deadlines:**

All forms must be received by Residence Life by the following dates in order to process your request. Requests received after the deadline will be considered on an as available basis.

Returning Students:	February 10 <sup>th</sup>
<b>Incoming New Students:</b>	<b>July 1st</b>

The attached *Three (3)* Forms have been developed to assist you in working with your diagnosing or treating professional to prepare the information needed to evaluate your request. Please complete the attached forms and return them to the Residence Life Office (by mail or fax). Support documentation must also be on file in the University Wellness Center and Learning Services Office in order to fully evaluate your request.

Questions about the Special Housing Request process may be directed to the Residence Life Office at [residencelife@msmary.edu](mailto:residencelife@msmary.edu) or by contacting the Office of Residence Life - Phone (301) 447-5274.

**Note for all students:** *The request for special housing takes priority above a request for particular roommates. Please call our office for more details. Due to electrical safety hazards, no air conditioners will be allowed in the Terrace. Specific rooms in Pangborn and Sheridan have been designed for this option.*

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### FORM 1: STUDENT REQUEST FOR SPECIAL HOUSING ACCOMMODATION

**Policy Statement:** A request for special housing will be reviewed on a case by case basis and submitting this request does not guarantee that your application will be approved. Students with the most severe needs will be given first priority in securing special housing if their need/disability significantly impacts an essential life function.

**Assignment to a specific residence hall cannot be guaranteed. For example, individual air conditioners are only allowed in specific rooms in Pangborn and Sheridan.**

**This form should be filled out by the student and returned to:**

Office of Residence Life  
Mount St. Mary's University  
Emmitsburg, MD 21727  
Fax: 301-447-5818

#### PLEASE PRINT OR TYPE

Student Name: \_\_\_\_\_

Cell/Campus Phone #: \_\_\_\_\_ Home Phone #: \_\_\_\_\_

E-mail: \_\_\_\_\_

Campus Address: \_\_\_\_\_

Permanent Address: \_\_\_\_\_

Incoming Freshman: \_\_\_\_\_ Transfer Student: \_\_\_\_\_ Returning Student: \_\_\_\_\_

Male: \_\_\_\_\_ Female: \_\_\_\_\_

Semester (s) Requested: Fall \_\_\_\_\_ Spring \_\_\_\_\_ Summer \_\_\_\_\_ 20 \_\_\_\_\_ - \_\_\_\_\_

My supporting documentation is on file in: (check all that apply) \_\_\_\_\_ Health Services  
\_\_\_\_\_ Learning Services

**(A) Requests for special housing accommodations will need to be submitted each academic year the student plans to live on-campus. The student will be notified in advance if more current documentation is needed each subsequent year a special housing accommodation is requested. In addition, the University, acting in good faith, reserves the right to request updated documentation at any time.**

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(B) The student agrees that any information provided in conjunction with this request can be reviewed as necessary by appropriate University staff to determine the response. In addition, the student grants permission for attending physicians and/or other professional providers to share information as requested by University staff. **STUDENTS MUST PROVIDE SUPPORTING DOCUMENTATION TO THE APPROPRIATE OFFICES (Health Services or Learning Services) IN ORDER TO BE CONSIDERED FOR SPECIAL HOUSING.**

Student Signature: \_\_\_\_\_

Date: \_\_\_\_\_

**TO BE COMPLETED BY STUDENT:**

Please provide a clear description of the requested housing accommodation(s).

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Please explain how the request relates to your disability.

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During the past school year, have you visited your doctor or the Wellness Center for treatment due to the disability?

\_\_\_\_\_ Yes                      \_\_\_\_\_ No

If yes, please provide number of times and attach documentation (if possible) of your visits.

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<b>FORM 2: DOCUMENTATION OF MEDICAL DISABILITY</b>
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Student Name: \_\_\_\_\_

Student ID Number: \_\_\_\_\_

Date: \_\_\_\_\_

Dear Doctor/Health Professional: Please answer each question in the space provided. We appreciate your providing detailed information so the Special Housing Review Group can make an appropriate decision.

A disability is defined under the Americans with Disabilities Act as “a physical or mental impairment that **substantially** limits a major life activity”.

Examples of major life activities are: walking, speaking, breathing, hearing, seeing, thinking, sitting, sleeping, working, learning, interacting with others, concentrating, performing manual tasks, or caring for oneself.

1. Based on this definition does the individual have a physical or mental impairment?  
\_\_\_\_\_ Yes    \_\_\_\_\_ No

If the answer to question 1 is yes, please answer the following questions:

- a. What specifically is the impairment?

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

- b. Which major life activities are limited by the impairment?

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

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c. How many days/months did the impairment limit major life activities during the past year?

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d. What is the expected duration of the impairment?

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e. What are the expected permanent or long-term effects of the impairment?

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f. Does the student take medication(s)? \_\_\_\_ Yes \_\_\_\_ No

g. List medication(s):

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h. Does medication(s) relieve the symptoms?

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2. State specifically what special housing accommodations you recommend and what benefits these accommodations will have with regard to the individual's impairment.

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3. Please provide any additional information that you feel would be helpful to the Special Housing Review Group.

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*I, the undersigned diagnostic/treating professional, certify that the above named student:*

- Check One:**  Meets the definition of a **disability\*** as defined by the American's with Disabilities Act & Section 504 of the Rehabilitation Act of 1973.  
*\*Impairment that substantially limits a major life activity.*
- Has a medical condition that is not a disability, but may warrant consideration for special housing modifications.
- Does not have a condition that would require the requested modification(s).

**Doctor's Name: (Please print)**

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**Signature:**

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**Doctor's Address:**

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**Doctor's Phone Number:** \_\_\_\_\_

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## FORM 3: STUDENT REQUEST FOR AIR CONDITIONING

Student Name: \_\_\_\_\_

Student ID Number: \_\_\_\_\_

**Medical Provider Information: Asthma & Allergies** (This form is to be completed by a health professional) **Please complete all the following categories that apply to assist Mount St. Mary's in determining your patient's need for air-conditioned housing. The information which you provide will become a part of your patient's medical record at Mount St. Mary's. Thank you for your assistance.**

**Consent for Release of Information:** I, \_\_\_\_\_, give  
*Student Name*  
\_\_\_\_\_ permission to provide the information  
*Medical Provider*

requested below to the Residence Life Office at Mount St. Mary's University. I understand that this information will be shared with the Special Housing Review Group. I also understand that this information will become a part of my permanent medical record at Health Services.

\_\_\_\_\_  
Student Signature

\_\_\_\_\_  
Date

### ASTHMA

**1. Current Diagnosis (select one)**

- Exercise Induced Asthma
- Intermittent Asthma
- Persistent Asthma
- Other (please define)

**2. Current Asthma Medications (please note medication name, dosage, and how often student takes)**

- Short-Acting Beta Agonists  
\_\_\_\_\_
- Long-Acting Beta Agonists  
\_\_\_\_\_
- Inhaled Corticosteroids  
\_\_\_\_\_
- Other  
\_\_\_\_\_  
\_\_\_\_\_

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### 3. Please check any of the following which are true for your patient (dates required)

- History of severe asthma exacerbations requiring emergency care (most recent date)\_\_\_\_\_
- Prior intubation for asthma\_\_\_\_\_
- Hospital admission for asthma (most recent hospitalization date)\_\_\_\_\_
- Prior office visits for asthma exacerbation (most recent 3 visit dates)\_\_\_\_\_
- Prior use of IM or oral corticosteroids for asthma (most recent date prescribed)\_\_\_\_\_
- Currently requires more than 2 canisters of short-acting beta agonist per month\_\_\_\_\_

## ALLERGIES

### 1. Current Diagnosis

- Allergic Rhinitis (Circle one): Seasonal Perennial
- Allergic Conjunctivitis
- Other (diagnosis)\_\_\_\_\_

### 2. Current Allergy Medications (include medication name and frequency of daily use)

- Antihistamines\_\_\_\_\_

- Steroid Nasal Inhaler\_\_\_\_\_

- Other\_\_\_\_\_

### 3. Please check any of the following which are true for your patient

- Allergies documented by skin testing or other diagnostic testing
- Prior or current immunotherapy (allergy shots)

**MEDICAL PROVIDER COMMENTS:** Use reverse side if necessary. *Please Print.*

Medical Provider Name: \_\_\_\_\_

Date: \_\_\_\_\_

Medical Provider Signature: \_\_\_\_\_

**Return to:** Office of Residence Life  
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Emmitsburg, MD 21727  
Fax: 301-447-5818