UNIVERSITY of WISCONSIN
UWMILWAUKEE

University Housing

***Business Administration Office***
3400 N. Maryland Ave.
Milwaukee, WI
53211-2953
414-229-4065 phone
414-229-4127 fax
www.universityhousing.uwm.edu

# HOUSING ACCOMMODATION REQUEST FORM
## (Based on Disability or Medical Need)

*Priority Deadline: Fall—July 1st  Spring—January 1st*

Students with a disability or medical needs which require accommodations relating to a residence hall space (accessible shower stall, larger doorway, doorbells with light flashers, Braille signs, etc.) should notify University Housing by submitting this form. University Housing will refer your request to UWM's Accessibility Resource Center (ARC). As part of ARC's intake process, you may be asked to complete additional forms or submit documentation from your health care provider to support your request. Please refer to the Forms section (http://www4.uwm.edu/sac/zforms.html) for potential forms that you may need to submit.

**Return this form and supporting documentation via one of these methods:**
Mail: University Housing, 3400 N. Maryland Ave, Milwaukee WI 53211
Fax: 414.229.4127
Email: university-housing@uwm.edu, subject "Accommodation Request"

| | |
|---|---|
| **Resident Name (print):** | **Campus ID:** |
| Resident Cell Phone #: | Street Address: |
| UWM E-Mail Address: @uwm.edu | City |
| Term of Entry (circle one): FALL SPRING SUMMER **Year:** | State Zip Code |

**Please provide a detailed description of your accommodation request.** Please also consider what your needs are related to an emergency evacuation, natural disaster, etc. when completing this form.

**Are you requesting any accommodations to be supplied by University Housing?**

- ☐ Wheel Chair Accessible Room
- ☐ Bed Shaker
- ☐ Doorbell with flashing light
- ☐ Other (please indicate): _____

| | |
|---|---|
| Student Signature | Date |

| *For Office Use Only* | | |
|---|---|---|
| *Initial and Date once completed* | **Route to the Assistant Director-Business Administration** | Time Stamp |
| | *Route to ARC* | |
| | *Enter into spreadsheet* | |
| | *Notify student of decision* | |
| | *Update spreadsheet with decision & inform Accounts Manager* | |

## Accessibility Resource Center Psychiatric Disability Assessment Form

The University of Wisconsin-Milwaukee Accessibility Resource Center provides academic services and accommodations for students with disabilities. Students are required to provide documentation that verifies that a diagnosed condition meets the legal definition of a disability covered under Section 504 of the Rehabilitation Act (1973) and the Americans with Disabilities Amended Act (2008). These laws define a disability as a physical or mental impairment that substantially limits one or more major life activities. Eligibility for academic accommodations is based on documentation that clearly demonstrates a student has one or more functional limitations in an academic setting, and that one or more accommodations is needed to achieve equal access. See more information about ARC Disability Documentation Guidelines on our website.

**TO BE COMPLETED BY PHYSICIAN OR MEDICAL PROFESSIONAL ONLY**

A client of yours has requested disability-related accommodations with services. As this client's treating clinician/specialist, you are asked to provide the following information to allow the university to consider this client's service request(s).

**Please complete the following:**

| **1. Student Information:** | |
|---|---|
| Client Name: | |
| Preferred Name: | |
| Date of Birth (mm/dd/yyyy): | |

| **2. Diagnosis: What is the DSM-IV-R or DSM 5 Diagnosis? (Please include all if multiple.)** |
|---|
| |
| |
| |
| |
| |
| **Are there any diagnoses that need to be ruled out?** |

**3. Date of Diagnosis:**
**4. Date of First Contact with Client:**
**5. Date of Last Contact with Client:**

**6. In addition to applying DSM-IV-R diagnostic criteria, what other information did you collect to arrive at your diagnosis?**

- ☐ Behavioral observations
- ☐ Developmental history
- ☐ Rating scale (e.g., Beck Depression Scale, etc.)
- ☐ Medical History
- ☐ Structured or unstructured clinical interview with the student
- ☐ Interviews with others (parents, teachers, spouse or significant others)
- ☐ Neuropsychological, psycho educational testing, etc. **Date(s) of testing:** _____

**7. Has this student been hospitalized or received in-patient care for their disorder in the past?**
☐ Yes ☐ No
**If yes, what has been the frequency and typical duration of these treatments?**

**8. Is the student currently receiving psychotherapy?** ☐Yes ☐No
**If yes, how often?**

**9. Are there any significant limitations to the student's functioning directly related to the prescribed medications (if known)?**

**10. If you are the prescribing clinician, is the student compliant with the use of medications and treatment?** ☐Yes ☐No; please explain:

**FUNCTIONAL IMPACT ASSESSMENT (REQUIRED) – Part A**
**11A. What methods were utilized to assess functional limitation? Please list or attach a separate page.**

**FUNCTIONAL IMPACT ASSESSMENT (REQUIRED) – Part B**

**11B. Please rate the frequency/duration and severity (using an "x") of the condition's impact on major daily life activities to the best of your knowledge. For comparison purposes, please use same age peers in a postsecondary setting.**

| Major Life Activity | Frequency/Duration<br>0-4 Scale<br>0=never, 1=rarely,<br>2=intermittent,<br>3=daily/frequent,<br>4=chronic | Unknown/ N/A | Mild | Moderate | Severe |
|---|---|---|---|---|---|
| **Initiating Activities** | | | | | |
| **Concentration** | | | | | |
| **Following Directions** | | | | | |
| **Memorization** | | | | | |
| **Persistence** | | | | | |
| **Processing Speed** | | | | | |
| **Organizational Skills** | | | | | |
| **Sustained Reading** | | | | | |
| **Sustained Writing** | | | | | |
| **Problem Solving** | | | | | |
| **Listening** | | | | | |
| **Sitting** | | | | | |
| **Speaking** | | | | | |
| **Interacting with Others** | | | | | |
| **Sleeping** | | | | | |
| **Other: Please Specify** | | | | | |
| **Other: Please Specify** | | | | | |

**SYMPTOM ASSESSMENT (REQUIRED)**

**12. Please rate the frequency/duration and severity (using "x") of the symptoms as related to the disability.**

| Symptom | Frequency/Duration<br>0-4 Scale<br>0=never, 1=rarely<br>2=intermittent,<br>3=daily/4=frequently,<br>5=chronic | Unknown/ N/A | Mild | Moderate | Severe |
|---|---|---|---|---|---|
| **Compulsive Behaviors** | | | | | |
| **Delusions** | | | | | |
| **Depressed Mood** | | | | | |
| **Disordered Eating** | | | | | |
| **Fatigue/Loss of Energy** | | | | | |
| **Hallucinations** | | | | | |
| **Impulsive Behaviors** | | | | | |
| **Mania** | | | | | |
| **Obsessive Thoughts** | | | | | |
| **Panic Attacks** | | | | | |
| **Phobia (Specify)** | | | | | |
| **Physiological Symptoms:** | | | | | |
| ☐ Dizziness | | | | | |
| ☐ Fainting | | | | | |
| ☐ Racing Heart | | | | | |
| ☐ Migraines/Head Aches | | | | | |
| ☐ Nausea | | | | | |
| ☐ Chest Pain | | | | | |
| ☐ Shortness of Breath | | | | | |
| ☐ Other | | | | | |
| ☐ Other | | | | | |
| **Racing Thoughts** | | | | | |
| **Self Injurious Behavior** | | | | | |
| **Suicidal Ideation** | | | | | |
| **Suicide Attempts** | | | | | |
| **Unable to Leave the House** | | | | | |
| **Other:** | | | | | |

**13. Please list your recommendations for accommodations within the academic environment. (See a listing of common accommodations on the ARC website.) Please provide an explanation or rational for the recommendation. If available in a separate report, please attach that report.**

| Accommodation Recommendation | Rationale |
|---|---|
| | |
| | |
| | |
| | |

**15. Certifier Information:**

| | |
|---|---|
| **Clinician Name (Print):** | |
| **Clinician Name (Signature):** | |
| Medical Specialty: | |
| License #: | |
| Address: | |
| Phone: | |
| Email: | |
| **Date of this Report:** | |

**Please send this completed form and any additional documentation to:**

**Accessibility Resource Center**
**University of Wisconsin-Milwaukee**
**Mitchell Hall, Room 112**
**P.O. Box 413**
**Milwaukee, WI 53211**
**(Fax) 414-229-2237**
**archelp@uwm.edu**

**If you have questions, please feel free to contact our office at 414-229-6287. Thank you.**

# Accessibility Resource Center Disability Assessment Form

Blind/Low Vision, Chronic Health, Deaf & Hard of Hearing, Mobility, Traumatic Brain Injury

The University of Wisconsin-Milwaukee Accessibility Resource Center provides academic services and accommodations for students with disabilities. Students are required to provide documentation that verifies that a diagnosed condition meets the legal definition of a disability covered under Section 504 of the Rehabilitation Act (1973) and the Americans with Disabilities Amended Act (2008). These laws define a disability as a physical or mental impairment that substantially limits one or more major life activities. Eligibility for academic accommodations is based on documentation that clearly demonstrates a student has one or more functional limitations in an academic setting, and that one or more accommodations is needed to achieve equal access. *See Disability Documentation Guidelines*

**TO BE COMPLETED BY PHYSICIAN OR MEDICAL PROFESSIONAL ONLY**

A client of yours has requested disability-related accommodations with services. As this client's treating clinician/specialist, you are asked to provide the following information to allow the university to consider this client's service request(s).

**Please complete the following:**

**1. Student Information:**

| | |
|---|---|
| Client Name: | |
| Preferred Name: | |
| Date of Birth (mm/dd/yyyy): | |

**2. Diagnosis:**

| | |
|---|---|
| What is the diagnosis? | |
| Date of original diagnosis: | |
| Is the client currently under your care? | ☐ Yes ☐ No |
| When did you last see the client? | |
| Is the condition temporary (< 6 months) or persistent? | |
| Please identify factors that may affect the severity of the condition (e.g., to what degree might the condition be *minimized* by medications, hearing aids, etc.?) Alternatively, could there be an adverse effect (e.g., medication side effects)? | |

**3. FUNCTIONAL IMPACT ASSESSMENT (REQUIRED)**

**Please rate the frequency/duration and severity (using "x") of the condition's impact on major daily life activities to the best of your knowledge. For comparison purposes, please use same age peers in a postsecondary setting.**

| Major Life Activity | Frequency/Duration 0-4 Scale 0=never, 1=rarely, 2=intermittent, 3=daily/frequently, 4=chronic | Severity | | | |
|---|---|---|---|---|---|
| | | Unknown/ N/A | Mild | Moderate | Severe |
| Caring for Oneself | | | | | |
| Talking | | | | | |
| Hearing | | | | | |
| Breathing | | | | | |
| Seeing – Close Distance | | | | | |
| Seeing – Long Distance | | | | | |
| Lifting/Carrying | | | | | |
| Sitting | | | | | |
| Performing Manual Tasks | | | | | |
| Eating | | | | | |
| Sleeping | | | | | |
| Standing/Walking | | | | | |
| Learning | | | | | |
| ❑ Reading | | | | | |
| ❑ Writing | | | | | |
| ❑ Spelling | | | | | |
| ❑ Calculating | | | | | |
| ❑ Concentrating | | | | | |
| ❑ Memorizing | | | | | |
| ❑ Listening | | | | | |
| ❑ Speaking | | | | | |
| ❑ Other: | | | | | |
| ❑ Other: | | | | | |

**4. What method(s) were utilized to assess functional limitation? Please list or attach under separate cover.**

**5. Please list your recommendations for accommodations within the academic environment and provide an explanation or rationale for the recommendation utilizing data from objective measures, the educational record or other data sources. If available in a separate report, please attach that report.**

| Accommodation Recommendation | Rationale |
|---|---|
| | |
| | |
| | |
| | |

**6. Certifier Information:**

| | |
|---|---|
| Clinician Name (print) | |
| Clinician Name (signature) | |
| Medical Specialty | |
| License | |
| Address | |
| Phone | |
| Email | |
| Date | |

**Please send this completed form and any additional documentation to:**

**Accessibility Resource Center**
**University of Wisconsin-Milwaukee**
**Mitchell Hall, Room 112**
**P.O. Box 413**
**Milwaukee, WI 53211**
**(Fax) 414-229-2237**
**archelp@uwm.edu**

**If you have questions, please feel free to contact our office at 414-229-6287. Thank you.**

# Accessibility Resource Center AD/HD Disability Assessment Form

## INTRODUCTION

The University of Wisconsin-Milwaukee, Accessibility Resource Center provides academic services and accommodations for students with disabilities. Students are required to provide documentation that verifies that a diagnosed condition meets the legal definition of a disability covered under Section 504 of the Rehabilitation Act (1973) and the Americans with Disabilities Amended Act (2008). These laws define a disability as a physical or mental impairment that substantially limits one or more major life activities. Eligibility for academic accommodations is based on documentation that clearly demonstrates a student has one or more functional limitations in an academic setting, and that one or more accommodations is needed to achieve equal access.

## AD/HD DOCUMENTATION REQUIREMENTS

Documentation that is most helpful in determining eligibility consists of:

- a thorough developmental, educational and medical history;
- standardized rating scales;
- structured or unstructured clinical interview with the student;
- behavioral observations;
- corroborative data gathered from parents, teachers, spouse or significant others;
- neuropsychological or psychoeducational assessment that demonstrates the impact of AD/HD on cognitive processing and academic achievement.

## COMPLETING THE ARC AD/HD DISABILITY ASSESSMENT FORM

The AD/HD Disability Assessment Form must be completed as thoroughly as possible by a qualified healthcare professional. A qualified healthcare professional is typically a licensed clinical psychologist, neuropsychologist, psychiatrist, or a medical specialist trained in mental health assessment. This professional has comprehensive training and relevant experience in the full range of psychiatric disorders and uses a differential diagnostic practice to arrive at the AD/HD diagnosis.

A comprehensive diagnostic report including psycho-educational or neuropsychological test results may be submitted in lieu of this form.

Inadequate information, incomplete answers and/or illegible handwriting will delay the eligibility review process and require follow up contact for clarification.

After completing the AD/HD Disability Assessment Form and the Certifier Information/Credentials section on the last page, please mail or fax the form to the Accessibility Resource Center (fax: 414-229-2237). If you have any questions regarding this form, please feel free to contact us at archelp@uwm.edu. Thank you for your assistance.

# Attention Deficit/Hyperactivity Disorder Disability Assessment Form

- This form is to be completed by a qualified healthcare professional.
- This form can be completed electronically in Microsoft Word and then printed and signed (preferred) OR it can be printed and completed legibly in ink.

**STUDENT INFORMATION**

| | |
|---|---|
| **Client Name:** | |
| **Preferred Name:** | |
| **Date of Birth (mm/dd/yyyy):** | |

**DIAGNOSTIC INFORMATION**

Please provide responses to the following items by completing this form electronically or writing in a legible fashion. Illegible forms will delay the documentation review process for the student.

1. **DSM-IV-R or DSM 5 Diagnosis: (REQUIRED)**

| | Date of Original Dx |
|---|---|
| | |
| | |
| | |
| | |
| | |

2. **Differential Diagnoses:**
   What other diagnoses were considered and why were they ruled out?

3. **Contact with Student:**
   Date of first contact with student: (mm/dd/yyyy)
   Date of last contact with student: (mm/dd/yyyy)

**4. Diagnostic Information:**

What information was collected to arrive at the diagnosis? (Please attach/fax diagnostic report of assessment(s) if available)

- ☐ Behavioral observations
- ☐ Developmental history
- ☐ Rating scales
- ☐ Medical history
- ☐ Structured or unstructured clinical interview with the student
- ☐ Interviews with others (parents, teachers, spouse or significant others)
- ☐ Neuropsychological or psycho-educational testing

Date(s) of testing: (mm/dd/yyyy)

- ☐ Other (Please specify):

**5. Current Treatment Plan:**

What is the student's current treatment plan (e.g., medication, counseling, coaching, learning strategies instruction, etc.)? How effective is the plan in mitigating the impact of the disorder in *learning* and *what* is the student's compliance in adhering to the plan?

| **Type of Treatment** | **Frequency /Duration** (weekly, biweekly, monthly, other) | **Compliance** (0-4 Scale, with 4 most compliant) | **Effectiveness** (0-4 Scale, with 4 most effective) | **Adverse side effects** (please explain) |
|---|---|---|---|---|
| Medication – | | | | |
| Counseling or Psychotherapy – | | | | |
| Other | | | | |

**6. <u>Assessment of a Functional Limitation to Learning:</u>**

Please rate the frequency/duration and severity (using "x") of the condition's impact on major daily life activities to the best of your knowledge. For comparison purposes, please use same age peers in a postsecondary setting.

| Major Life Activity | **Frequency/Duration 0-4 Scale** 0=never, 1=rarely, 2=intermittent, 3=daily/frequently, 4=chronic | **Severity** | | | |
|---|---|---|---|---|---|
| | | **Unknown/ N/A** | **Mild** | **Moderate** | **Severe** |
| Initiating Activities | | | | | |
| Concentration | | | | | |
| Following Directions | | | | | |
| Memorization | | | | | |
| Persistence | | | | | |
| Processing Speed | | | | | |
| Organizational Skills | | | | | |
| Sustained Reading | | | | | |
| Sustained Writing | | | | | |
| Problem Solving | | | | | |
| Listening | | | | | |
| Sitting | | | | | |
| Speaking | | | | | |
| Interacting with Others | | | | | |
| Sleeping | | | | | |
| Other: please specify- | | | | | |
| Other: please specify- | | | | | |

**7. <u>Specific Accommodation Recommendations</u>:**
Please list your recommendations for accommodations within the academic environment. See a listing of common accommodations at http://uwm.edu/arc/services-and-accommodations/. If available in a separate report, please attach that report.

| Accommodation Recommendation | Rationale |
|---|---|
| | |
| | |
| | |
| | |

**CERTIFIER INFORMATION/CREDENTIALS (REQUIRED):**

| **Date** | |
|---|---|
| Clinician Name (print) | |
| Clinician Name (signature) | |
| Medical Specialty | |
| License | |
| Address | |
| Phone | |
| Email | |

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

**Accessibility Resource Center**
**University of Wisconsin-Milwaukee**
**Mitchell Hall, Room 112**
**P.O. Box 413**
**Milwaukee, WI 53211**
**(Fax) 414-229-2237**
**archelp@uwm.edu**
**www.uwm.edu/arc**

If you have any questions, please feel free to contact our office at 414-229-6287.
Thank you.