

Verification Form for Housing Accommodations at OBU

Student's Name: _____ OBU ID# _____

Current or anticipated OBU housing location (Building and room #): _____

I authorize the ADA 504 Accommodations Coordinator of Ouachita Baptist University (OBU) to receive information from my provider (name) _____. I also authorize my provider to discuss my condition(s) and treatment history with the appropriate and qualified OBU personnel on an as needed basis.

Student Signature: _____ Date: _____

In order to determine reasonable accommodations for housing, OBU requires current and comprehensive documentation of the student's condition from a licensed clinical mental health professional or the student's current treating health care provider. If the space provided is not adequate, please attach a separate sheet of paper. The provider may also attach a report providing additional related information. This form's completion does NOT guarantee that a request will be granted.

Student, be advised that an Emotional Support Animal (ESA) will not likely be granted a student who is not currently attending psychotherapy to address his/her mental health condition, and has for at least three months, involving weekly or bi-weekly sessions provided by a licensed mental health clinician.

The deadlines for current students submitting a request for fall housing accommodations are as follows:

- **March 16th for students in OBU Residence Halls or OBU owned apartments**

The remainder of this form must be completed by the licensed clinical mental health professional or health care provider currently treating the student, and who is familiar with the history and functional limitations of the student's current disabling condition(s). This professional may NOT be a relative of the student.

Name of professional completing form: _____

Qualifications/Credentials: _____

Relationship to above named student: _____

1) Date of Initial Contact with Student: ___/___/___ 2) Date of student's Last Office Visit: ___/___/___

3) Student's medical or mental health diagnosis (give title and ICD 10 codes) _____

4) Clinician: Do you assert or affirm that the above named student has a current medical or mental health diagnosis or condition (if not yet fully or clearly diagnosed) which creates symptoms so severe that it substantially limits or impairs the student's functioning in at least one or more major life activities? **Yes / No**

5) Approximate onset of diagnosis: ___/___/___ Symptom(s) severity: ___mild ___ moderate ___ severe Prognosis of disorder: ___ good ___ fair ___ poor

Expected duration of medical condition: _____

6) **It is not sufficient to assert that a student will "benefit" from a particular suggested accommodation. For any condition to be identified as a disability, it must create such severe symptoms or restriction to the person's daily functioning that it substantially limits one or more major life activities.** Please describe the symptoms related to the student's condition that cause significant impairment in a **major** life activity.

6) If a mental health condition is at the core of the student's disability, please list the interventions that have already been applied to the patient's condition to help alleviate or reduce its debilitating effects, though with inadequate results, thereby necessitating additional housing accommodations (e.g., psychotropic or other appropriate medications, 3 months of CBT, Exposure Therapy, DBT, EMDR, modified academic schedule, etc.).

- a) _____
- b) _____
- c) _____

7) Is the requested housing accommodation something that may benefit the student's functioning, or is it clear that it is an **essential necessity** to the student's functioning? If the latter, how was this judgement made? What evidence exists to support that conclusion?

8) If a private room is what is being requested, would a well-matched, considerate, and reasonably mature, accommodating roommate be a suitable response to the student applicant's need? _____

9) Please state the clinician's specific housing related recommendations, based upon the student's disability (if the student suffers from a mental health related disability please give particular attention to how the accommodation will alleviate a specific disabling symptom of the student's condition).

10) Anticipated duration of requested accommodation (include explanation if longer than 2 semesters, unless condition is permanent/lifelong): ____ 1 Semester ____ 2 Semesters ____ Entire OBU education (*this duration of accommodation will not be granted for most mental health disabling conditions*)

Explanation: _____

Thank you for your help in providing this information. Please complete the provider information below. This form should be signed and returned via fax or mail to our ADA 504 Accommodations Coordinator at the address, email or fax number below. All documentation submitted to this office is considered confidential, but may be discussed, as needed for consultation, with the OBU Housing Director and/or the Vice President for Student Development, Wesley Kluck, MD.

Provider Information

I certify, by my signature below, that I conducted or formally supervised and co-signed the diagnostic assessment of the student named above, and that all of the information on this form is accurate.

Signature: _____ Date: ____/____/____

Print Name and Title: _____

State of License: _____ License Number: _____

Office Address: _____

City: _____ State: ____ Zip Code: _____

Phone: _____

Fax: _____

Provider, please fax this completed form, from your office, to:

Daniel Jarboe
Counseling Services & ADA 504 Coordinator
 Ouachita Baptist University
 410 Ouachita, Box 3646
 Arkadelphia, AR 71998-0001
Fax: (870) 245-5341

