The following questionnaire must be filled out by an M.D. or other qualified medical provider with expertise in the area of concern. Chiropractor, Physical Therapist, and Massage Therapist are examples of what would not be considered acceptable for the purposes of this documentation.

NOTE: Incomplete documentation will result in the necessity of further communication with the medical provider.

Requests for housing accommodations require documentation of a disabling condition and substantiated limitations in function or performance. The disabling condition must significantly restrict the student’s access to our standard Campus Housing environment unless reasonable accommodations are provided. Approval of requests is determined on a case-by-case basis.

I) Presenting diagnosis of individual’s medical condition (please indicate primary, secondary, etc. and significant findings specifically relevant to the presenting problems):

_______________________________________________________________________________
_______________________________________________________________________________
_______________________________________________________________________________
_______________________________________________________________________________
_______________________________________________________________________________

II) Diagnostic code (ICD or DSM III-R, IV):

_______________________________________________________________________________

Level of Severity: (Please circle)
Mild Moderate Severe Partial Remission Residual State

Date of Diagnosis: ________________ Date of last visit: ________________

III) Is the condition temporary or permanent? If temporary, please indicate longevity:

_______________________________________________________________________________
_______________________________________________________________________________

IV) Has medication been prescribed, and if so, does the condition continue to affect the student’s functioning in the same way?

_______________________________________________________________________________
_______________________________________________________________________________
_______________________________________________________________________________
V) Identify limitations in function or performance (which are supported by medical evidence) in activities such as mobility, self-care, housing conditions/arrangements and necessary housing modifications (i.e., how is the requested accommodation necessary to the student’s capacity to function in a traditional University setting?)

____________________________________________________________________________
____________________________________________________________________________
____________________________________________________________________________
____________________________________________________________________________
____________________________________________________________________________

VI) **Medical Single**: Frequently students request a single room because of a medical condition. The Documentation of Need and the severity of the condition may warrant prioritization for a single room, but do not rise to the level of a "Medical Single". The term Medical Single applies to cases where the student would be unable to participate in Campus Housing if they did not receive approval for a single room.

**Student's condition rises to level where he/she would be incapable of residing on campus without a "Medical Single".** Yes ____ No ____

*Medical evidence must support this request.*

Note: *In the case of a meal plan modification/exemption request, the student will be required to consult with Dining Services Registered Dietitian if questions VI and VII are unanswered.*

VII) If applicable, describe specific food limitations related to the student’s diagnosis, including foods to avoid and foods allowed:

____________________________________________________________________________
____________________________________________________________________________
____________________________________________________________________________

VIII) If applicable, provide a sample menu including meals and snacks for at least one day:

____________________________________________________________________________
____________________________________________________________________________
____________________________________________________________________________
____________________________________________________________________________
Print Name, Title, and Credentials:

________________________________________

Address: ________________________________________________________________

Phone: ________________________________________________________________

Signature: _____________________________________      Date_________________________

Questions may arise during the processing of this application. Please obtain a Release of Information form between your Medical Provider and University of Maine Disability Services or Housing / Dining personnel in order to expedite the conveyance of the information.

Thank you for your help in providing this information.

Please return this form to:

HOUSING MODIFICATION REQUESTS
Sara Henry
Disability Support Services
University of Maine
East Annex
Orono, ME 04469-5757
207.581.2319
Fax: 207.581.9420
email: sara.henry@umit.maine.edu

DINING SERVICES MEAL PLAN MODIFICATION REQUESTS
Director of Culinary Services
Dining Services
University of Maine
5734 Hilltop Commons, Suite 103
Orono, ME 04469-5734
207.581.4712
Fax: 207.581.4714

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