Procedure for Requesting Housing Accommodation(s)

1. Apply for On-Campus Housing: [https://www.csudh.edu/housing/](https://www.csudh.edu/housing/)
2. Apply for academic accommodation with the Student disAbility Resource Center (SdRC)
3. Have the licensed medical professional complete the applicable SdRC disability form in its entirety.
   - Disability Verification form
   - Verification Form for Medical and Physical Disabilities
   - Verification Form for Psychiatric and Learning Disabilities
   - ESA form (if applicable)
4. Complete the online Housing Accommodation Request Form
   a. [https://hood.accessiblelearning.com/CSUDH/ApplicationHousing.aspx](https://hood.accessiblelearning.com/CSUDH/ApplicationHousing.aspx)
5. Submit the SdRC disability form (see question 3)

Please Note:
- Student must have applied for CSUDH University Housing via the CSUDH University Housing Portal: [https://www.csudh.edu/housing/](https://www.csudh.edu/housing/)
- Students must be eligible for university-owned housing and meet deadlines and payments as established by the CSUDH University Housing Administration. If you are concerned about your housing eligibility, please consult the Housing Administration. Their contact information can be found at [https://www.csudh.edu/housing/contact/](https://www.csudh.edu/housing/contact/)
- Housing accommodations are based on a documented disability need and are evaluated on a case-by-case basis.
FORM FOR DOCUMENTING MEDICAL AND PHYSICAL DISABILITIES

The outline below was designed to help the student in working with the treating or diagnosing healthcare professional in obtaining the specific information to evaluate eligibility for academic accommodations.

1) **This form is to be filled out by healthcare professionals qualified to diagnose and recommend accommodations for students with medical or physical disabilities.**

2) **All parts of the form must be completed as thoroughly as possible.** Inadequate information, incomplete answers, and/or illegible handwriting will delay the eligibility review process by necessitating follow-up contact for clarification.

3) **The health care provider should attach any reports which provide additional related information.** In addition to the requested information, please attach any other information you think would be relevant to the student’s academic adjustment.

Please note that this form does not guarantee accommodations or services. Further assessment and collaboration between the student and the Student disAbility Resource Center are needed.

**AUTHORIZATION FOR RELEASE OF PRIVATE MEDICAL INFORMATION***

TO: ____________________________________________

(Medical/mental health care professional and/or clinic, medical practice, or hospital)

Under the Health Care Information Privacy Accountability Act (HIPAA), and the Federal Education Rights and Privacy Act (FERPA), I,___________________________________, authorize and order that the following information requested on the attached medical release form from California State University Dominguez Hills be completed in total, by an appropriate licensed professional (as applicable) and returned as soon as possible to the student or the Student disAbility Resource Center at California State University Dominguez Hills.

This confidential information will be used to ascertain the educational and functional limitations imposed upon me by my disability, per the requirements for academic accommodation and services under Title V of the California Educational Code, Section 504 of the Rehabilitation Act of 1973, and the Americans with Disabilities Act of 1990. Further, I authorize and order that the information requested on the attached form from Alliant International University be transmitted in writing, via United States Mail, facsimile, or electronically, in as expeditious a manner as possible.

This release can be revoked at any time by me with proper notification in writing, and automatically upon my completion or departure from my studies at California State University Dominguez Hills.

I hereby authorize and order the completion of this order for medical information made by me on this day of - ________________. I certify that this authorization is made of my own volition, fully in compliance with Federal and State Laws.

_____________________________________     ______________________________________

Printed Name of Student                    Signature of Student

Date Signed: ________________ Date of Birth: ________________ Student ID#: _____________

*Note: The Medical Provider may require additional or alternative release forms.
I. Identifying Information: To be filled out by the student

Name: ______________________________________________________
Address: ______________________________________________________
Date of Birth: ______________________________________________________
Student ID: ______________________________________________________

The following sections are to be filled out by a healthcare professional.

Today’s Date:_______________

II. Professional Diagnosing Condition/Treatment Information:

1. Please indicate your profession: ___________________________________________________

2. How long has this student been under your care? _____________________________________

3. When was the last appointment with this student? ____________________________________

III. Diagnostic Information

1. Date of onset of condition: _______________

2. Diagnosis/impairment/disability (please be specific using the ICD-10 codes if known)__________
   ________________________________________________________________________________
   ________________________________________________________________________________

3. Did you make the diagnosis? Yes    No
   If not, who did? _________________________________________________________________

4. Severity of Condition (circle one):
   Mild    Moderate    Severe

5. Is the condition: Permanent or Temporary?

6. Prescribed medications(s): ________________________________________________________

7. Current treatment: ______________________________________________________________
   ________________________________________________________________________________
   ________________________________________________________________________________

8. Are there any co-existing conditions (physical, mental, cognitive) that should be considered in
   the accommodation plan? _________________________________________________________
   ________________________________________________________________________________

9. What is the prognosis of the condition? ______________________________________________

10. Are there any factors that may exacerbate the condition? ______________________________
    ________________________________________________________________________________
    ________________________________________________________________________________
### IV. Method of Assessment

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<td>Rating scales</td>
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### V. Functional Limitation/Impact on Daily Life Activities

1. What major life activities are affected because of the student’s physical or medical condition? Indicate the level of limitation for each.

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2. Describe how current symptoms impact the student’s ability to participate in academic or fieldwork (practicum/internship) experiences.

___________________________________________________________________________________________________
___________________________________________________________________________________________________
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___________________________________________________________________________________________________
VI. Recommended Accommodations
Recommendation for academic and fieldwork (practicum/internship) accommodations: Please include justification for each accommodation.

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VII. Certifying Professional (all the following must be filled out completely)
(Please attach your business card)

Print name/Credentials___________________________________________________________

Signature ___________________________________________________ Date ______________

License number _________________________________________________________________

Address _______________________________________________________________________

Telephone _____________________________________________________________________

For Office Use | Date Received: | Staff Initials: |
----------------|----------------|----------------|

2023/11
FORM FOR DOCUMENTING PSYCHIATRIC AND LEARNING DISABILITIES

The outline below was designed to help the student in working with the treating or diagnosing healthcare professional in obtaining the specific information to evaluate eligibility for academic accommodations.

1) **This form is to be filled out by healthcare professionals qualified to diagnose and recommend accommodations for students with psychiatric or learning disabilities.**

2) **All parts of the form must be completed as thoroughly as possible.** Inadequate information, incomplete answers, and/or illegible handwriting will delay the eligibility review process by necessitating follow-up contact for clarification.

3) **The health care provider should attach any reports which provide additional related information.** In addition to the requested information, please attach any other information you think would be relevant to the student’s academic adjustment.

Please note that this does not guarantee accommodations or services. Further assessment and collaboration between the student and the Student Disability Resource Center are needed.

**AUTHORIZATION FOR RELEASE OF PRIVATE MEDICAL INFORMATION***

TO: __________________________________________________________________________
(Medical/mental health care professional and/or clinic, medical practice, or hospital)

Under the Health Care Information Privacy Accountability Act (HIPAA), and the Federal Education Rights and Privacy Act (FERPA), I, ____________________________, authorize and order that the following information requested on the attached medical release form from California State University Dominguez Hills be completed in total, by an appropriately licensed professional (as applicable) and returned as soon as possible to the student or the Student Disability Resource Center at California State University Dominguez Hills.

This confidential information will be used to ascertain the educational and functional limitations imposed upon me by my disability, per the requirements for academic accommodation and services under Title V of the California Educational Code, Section 504 of the Rehabilitation Act of 1973, and the Americans with Disabilities Act of 1990. Further, I authorize and order that the information requested on the attached form from Alliant International University be transmitted in writing, via United States Mail, facsimile, or electronically, in as expeditious a manner as possible.

This release can be revoked at any time by me with proper notification in writing, and automatically upon my completion or departure from my studies at California State University Dominguez Hills.

I hereby authorize and order the completion of this order for medical information made by me on this day of __________________________. I certify that this authorization is made of my own volition, fully in compliance with Federal and State Laws.

_____________________________________     ______________________________________________
Printed Name of Student                    Signature of Student

Date Signed: _________________Date of Birth: ___________________Student ID#: ___________________

*Note: Medical providers may require additional or alternative release forms.
I. Identifying Information: To be filled out by the student.

Name: _________________________________________________________________
Address: _________________________________________________________________
Date of Birth: _________________________________________________________________
Student ID: _________________________________________________________________

II. Professional Diagnosing Condition/Treatment Information

The Professional must be qualified to diagnose a psychiatric disability. If medication is involved, a psychiatrist is preferred.

Today’s Date: _______________

1. Please indicate your profession (circle one):
   Psychologist          Psychiatrist      Medical Doctor   Licensed Professional Counselor
   Clinical Social Worker       Marriage Family Therapist

2. How long has this student been under your care? _____________________________________

3. When was the last time you saw this student? ________________________________________

III. Diagnostic Information

1. Date of onset of condition: _______________

2. DSM-5 diagnosis and ICD-10 Code: __________________________________________________

3. Did you make the diagnosis? Yes    No
   If not, who did? ___________________________________________________________

4. Severity of Condition (circle one):
   Mild         Moderate        Severe

5. Is the condition: Acute or Chronic?

6. Prescribed Medication(s): _________________________________________________________

7. Current treatment: ______________________________________________________________
   ___________________________________________________________________________

8. Are there any co-existing conditions (physical, mental, cognitive) that should be considered in
   the accommodation plans? ______________________________________________________
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9. What is the prognosis of the condition? ____________________________________________

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IV. Method of Assessment

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V. Functional Limitations/Impact on Daily Life Activities

1. What major life activities are affected because of the student’s psychological condition? Indicate the level of limitation for each.

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(Please attach your business card)

Print name/Credentials __________________________________________________________

Signature ___________________________________________________ Date ______________

License number __________________________________________________________________

Address __________________________________________________________________________

Telephone ________________________________________________________________________

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<th><strong>/<em>/</em>/</strong>___</th>
<th>Staff Initials:</th>
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REQUEST FOR INFORMATION:
Emotional Support Animal

Student’s Name: ____________________

Proposed ESA: ____________________

Information about the Student’s Disability
DSM-5 diagnosis and ICD-10 Code:

Does the student require ongoing treatment?

When did you first meet with the student regarding this their mental health diagnosis?

When was the last time you saw the student?

Information about the Proposed ESA.
Is the animal one that you specifically prescribed as part of treatment for the student, or is it a pet that you believe will have beneficial effects for the student while attending Dominguez Hills?

What symptoms will be reduced by having the ESA?
Is there evidence that an ESA has helped this student in the past or currently?
Are there other accommodations that could alleviate the student’s symptoms in the same way(s) as an ESA?

Importance of ESA to Student’s Well-Being
In your opinion, how important is it for the student’s well-being that an ESA be in the residence on campus?

What consequence, in terms of disability symptomology, may result if the accommodation is not approved?

Have you discussed the responsibilities associated with properly caring for an animal while engaged in typical college activities? Do you believe those responsibilities might exacerbate the student’s symptoms in any way?

Accommodation Recommendations
Are there any other accommodations you would recommend that would help the student in an educational setting?

Contact Information
Address:
Telephone:
Email and/or Fax:

In addition, please attach a business card.