STUDENT DISABILITY RESOURCE CENTER
Welch Hall D180
PHONE: (310) 243-3660
EMAIL: sdrc@csudh.edu

Procedure for Requesting Housing Accommodation(s)

1. Apply for On-Campus Housing: https://www.csudh.edu/housing/
2. Apply for academic accommodation with the Student disAbility Resource Center (SdRC)
    a. How to Register with SdRC: https://www.csudh.edu/sdrc/register-with-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
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/
- 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/
- Housing accommodations are based on a documented disability need and are evaluated on a case-by-case basis.

STUDENT DISABILITY RESOURCE CENTER
James L. Welch Hall (WH) 180

PHONE: (310) 243-3660
EMAIL: sdrc@csudh.edu
FAX: (310) 928-7267

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

Method	Indicate which method was utilized
Interview with the student	
Interviews with other persons	
Behavioral observations	
Developmental history	
Educational history	
Medical history	
Rating scales	
Other:	

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.

Area of Limitation	No Impact	Moderate Impact	Substantial Impact	Don't know	Area of Limitation	No Impact	Moderate Impact	Substantial Impact	Don't Know
Learning					Standing				
Memory					Reaching				
Concentration					Lifting				
Writing					Sitting				
Speaking					Walking				
Thinking					Seeing				
Reading					Hearing				
Eating					Breathing				
Social Interaction					Managing Deadlines				
Self-Care					Sleeping				
Managing Internal Distractions					Managing Internal Distractions				
Communicating					Test Taking				
Stress Management					Performing Manual Tasks				
Regular Class Attendance					Other:				
Organization					Other:				

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

_____

_____

_____

_____

VI. Recommended Accommodations

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

Recommended Accommodations	Justification

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

STUDENT DISABILITY RESOURCE CENTER
James L. Welch Hall (WH) 180

PHONE: (310) 243-3660
EMAIL: sdrc@csudh.edu
FAX: (310) 928-7267

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 b 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? _____

   _____
9. What is the prognosis of the condition? _____
10. Are there any factors that may exacerbate the condition? _____

IV. Method of Assessment

Method	Indicate which method was utilized
Interview with the student	
Interviews with other persons	
Behavioral observations	
Developmental history	
Educational history	
Medical history	
Rating scales	
Neuropsychological testing (please include a report with the student's permission)	
Psycho-educational testing (please include a report with the student's permission)	
Educational testing (please include a report with the student's permission)	
Other:	

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.

Area of Limitation	No Impact	Moderate Impact	Substantial Impact	Don't know	Area of Limitation	No Impact	Moderate Impact	Substantial Impact	Don't Know
Learning					Speaking				
Memory					Thinking				
Concentration					Reading				
Writing					Eating				
Social Interaction					Managing Deadlines				
Self-Care					Sleeping				
Managing Internal Distractions					Managing Internal Distractions				
Communicating					Test Taking				
Stress Management					Organization				
Regular Class Attendance					Other (indicate below):				

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

_____

_____

_____

_____

VI. Recommended Accommodations

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

Recommended Accommodations	Justification

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

DIVISION OF STUDENT AFFAIRS

STUDENT DISABILITY RESOURCE CENTER
James L. Welch Hall (WH) 180

PHONE: (310) 243-3660
FAX: (310) 928 -7267

REQUEST FOR INFOMRATION:
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.

Clinician's Printed Name	Clinician's Signed Name	Date	License #