Housing Requests for Medical Reasons

If a student has circumstances that warrant a special request for housing, the request must be made to Student Health Services and/or Disabilities Services. Students with documented disabilities are entitled to reasonable accommodations as per the Americans with Disabilities Act (ADA). Requests for such accommodations should be made through the Office of Disability Services. Please do not send this documentation to the Office of Residence Life.

Please review the following guidelines and return the attached forms along with all pertinent documentation.

Instructions to Student:

1. Complete the second page of this form.
2. Sign the Release of Information on the top of the third page of this form.
3. Have your health care provider complete the bottom of the third page of this form.
4. Submit all completed forms, along with any supporting documentation, and mail to the Executive Director of Health Services and/or the Director of Disability Services.

Decision Process:

- The Executive Director of Health Services and/or the Director of Disability Services will review the request and consult with the health care provider if necessary. All requests will be given due consideration, as per the Americans with Disabilities Act (ADA) guidelines of reasonable accommodations.

- The Director of Residence Life or designee will contact the student to inform him/her once a decision has been made regarding their housing status.

- The Office of Residence Life attempts to meet the request of all students. However, given the limited inventory of housing, not all requests will be granted, nor does this process guarantee a reservation of space.

Additional Notes:

- Single rooms are typically assigned in the middle of August for each fall semester, and the middle of January for each spring semester.

- Students with medically documented dietary needs will need to meet with the Director of Dining Services first to discuss if their needs can be met. Only students whose dietary needs cannot be met will be considered for East Meadow Lane apartments.

- Air conditioners must be floor standing models; window units are not allowed. The University will not provide air conditioning units to students.

Appeal Process:

- If the student is not satisfied with the outcome and wishes to appeal the final decision, the Associate Dean of Students (1 University Avenue, Lowell, MA 01854) will hear the appeal.
Housing Requests for Medical Reasons (to be completed by student)

Student Information

Name: __________________________________________________

Student ID #: _________________________

Address: ___________________________________________________________________________

Contact Phone #: _________________________ E-Mail Address: ______________________________

Health Care Provider's Information

Name: __________________________________________________

Address: ___________________________________________________________________________

Contact Phone #: _________________________

Contact Fax #: _________________________

Requesting

Single Room □    Air Conditioner □    Sharps Disposal Container □

East Meadow Lane Apartment (special dietary need that is medically documented) □

Documentation

The University will make every effort to reasonably accommodate your request with documented medical concerns. **Singles and other housing accommodations are limited.** Submission of this form and supporting documentation **does** not guarantee that your request will be met.

Please forward all documentation along with this form and release to the appropriate department:

Executive Director of University Health Services
University of Massachusetts Lowell
71 Wilder Street, Suite 5
Lowell, MA 01854-3091
Attention: Housing Request

Director of Disability Services
University of Massachusetts Lowell
61 Wilder Street, Floor 2
Lowell, MA 01854-3091
Attention: Housing Request
Housing Requests for Medical Reasons – CONFIDENTIAL

RELEASE OF INFORMATION (TO BE COMPLETED BY STUDENT)

I, _______________________________ hereby authorize the release of the following information to the
Executive Director of University Health Services and/or the Director of Disability Services at University of
Massachusetts Lowell for the purpose of determining my eligibility for special housing. This information may
include psychiatric care and/or treatment.

__________________________________       ___________________       _____________________________
UML ID#                                                           Date                                     Signature

(TO BE COMPLETED BY LICENSED HEALTH CARE PROVIDER)

Diagnosis(es): _____________________________________________________________________________
Diagnostic code(s) (ICD or DSM IV): __________________________________________________________
Level of Severity: ___________________________________________________________________________
Date of Diagnosis: ___________________________________________________________________________
Date of Hospitalization(s): __________________________________________________________________
Date of Surgery (ies): ________________________________________________________________________
Date of last visit: __________________________________________________________________________
Current Medication (s): ______________________________________________________________________
Currently under treatment? ___________________________________________________________________
Expected recovery/rehabilitation time: __________________________________________________________

Please specify in detail how this problem requires specialized housing: ________________________________
_________________________________________________________________________________________
_________________________________________________________________________________________
_________________________________________________________________________________________

Thank you for your help in providing this information. Please provide us with contact information, should we
need further information or to verify any of the documentation.

Provider’s Name: _______________________________________________________________________
License #: _____________________________________________________________________________
Address: ________________________________________________________________________________
_______________________________________________________________________________________
Phone: ___________________________________ Fax: ___________________________________
Signature: _____________________________________________________________________________
Date: _____________________________

The completed form should be mailed to:
Executive Director of University Health Services
71 Wilder St. Suite 5
Lowell, MA 01854-3091

or

Director of Disability Services
University of Massachusetts Lowell
61 Wilder Street, Floor 2
Lowell, MA 01854-3091

Note: The details of this medical documentation will not become part of the student’s academic record.