



UNIVERSITY HOUSING DOCUMENTATION GUIDELINES
DISABILITY PROVIDER FORM

Limestone University is committed to the full participation of students with disabilities in all aspects of college life. As a four-year residential university, learning to live in a community and share space with others is an integral part of our students' educational experience.

A standard housing assignment is a two-person sleeping room with bathroom facilities in either suite-style, adjacent to the room or on the same floor. Numerous campus locations provide quiet spaces for studying, including the library. Accommodations in the residential buildings are not granted based on a desire for a quiet, undisturbed place to study, but rather when determined that a standard residential assignment is not a viable option for this student.

Your patient/client has requested accommodations through The Office of Learning and Accessibility at Limestone University. The Office of Learning and Accessibility coordinates the collection and review of documentation in conjunction with the Director of Learning and Accessibility, Accessibility Education Services to provide reasonable accommodations for students with disabilities in accordance with Section 504 of the Rehabilitation Act of 1973, and with the Americans with Disabilities Act (ADA) of 1990 as amended in 2008, as well as other applicable state and federal laws.

Student's Name \_\_\_\_\_

Student's Date of Birth \_\_\_\_\_

To be considered eligible for reasonable accommodations, the following documentation is required: current medical documentation provided by a qualified professional such as a licensed physician, psychiatrist, licensed psychologist, clinical social worker, or other mental health professional which has been provided within three calendar years of the student's date of enrollment in Limestone University.

NOTE to PROVIDERS: Please submit this completed form along with a full description of the diagnostic methodology used, including data and measurements from appropriate evaluation instruments. The results obtained should draw a direct link to the diagnosis and the functional limitations of the disability. For cognitive disorders, evaluations should use adult norms. Complete documentation is important. Inadequate information, incomplete answers, and /or illegible handwriting may delay the eligibility review process for students.

- 1. Under the ADA, this student has a ... (please select) \_\_\_ Disability or \_\_\_ Temporary Impairment
2. Please cite the student's diagnosis/diagnoses:

DX #1: \_\_\_\_\_

Diagnostic code: \_\_\_\_\_ From: [ ] DSM-V [ ] IDC-10

Additional specifiers (if applicable) \_\_\_\_\_

Indicate if in:  Partial Remission     Full Remission     Prior History     Not Applicable

Comments (if necessary): \_\_\_\_\_

**DX #2:** \_\_\_\_\_

Diagnostic code: \_\_\_\_\_ From:  DSM-V     IDC-10

Additional specifiers (if applicable) \_\_\_\_\_

Indicate if in:  Partial Remission     Full Remission     Prior History     Not Applicable

Comments (if necessary): \_\_\_\_\_

**DX #3:** \_\_\_\_\_

Diagnostic code: \_\_\_\_\_ From:  DSM-V     IDC-10

Additional specifiers (if applicable) \_\_\_\_\_

Indicate if in:  Partial Remission     Full Remission     Prior History     Not Applicable

Comments (if necessary): \_\_\_\_\_

3. Please indicate the level of severity for each diagnosis using the scale below:

**Mild-** few if any symptoms present with minor impairments, may be distressing but manageable; symptoms confined to only one setting

**Moderate-** number of symptoms, intensity of symptoms, and/or functional impairment are between those specified for "mild" and "severe"; symptoms are present in at least two settings; intermediate

**Severe-** many symptoms in excess/ several symptoms that are particularly severe with marked impairment, may be seriously distressing and unmanageable, symptoms markedly interfere with functioning; symptoms are present in three or more settings; chronic

DX #1: \_\_\_\_\_ DX #2: \_\_\_\_\_ DX #3: \_\_\_\_\_

4. Please indicate the approximate frequency of symptoms experienced:

\_\_\_\_\_ **Periodic**    # of annual occurrences \_\_\_\_\_    \_\_\_\_\_ x per month    \_\_\_\_\_ most days

\_\_\_\_\_ **Seasonal**    # of annual occurrences \_\_\_\_\_    \_\_\_\_\_ x per week    \_\_\_\_\_ daily

5. How long do symptoms persist? \_\_\_\_\_

6. Please indicate the major life activity(ies) that are substantially limited by the disability/impairment:

\_\_\_\_\_ walking    \_\_\_\_\_ hearing    \_\_\_\_\_ seeing    \_\_\_\_\_ manual tasks

\_\_\_\_\_ reading    \_\_\_\_\_ working    \_\_\_\_\_ learning    \_\_\_\_\_ breathing

\_\_\_\_\_ lifting    \_\_\_\_\_ eating    \_\_\_\_\_ sleeping    \_\_\_\_\_ concentration

\_\_\_\_\_ speaking    \_\_\_\_\_ thinking    \_\_\_\_\_ standing    \_\_\_\_\_ communicating

\_\_\_\_\_ bending    \_\_\_\_\_ self-care    \_\_\_\_\_ the operation of major bodily functions

\_\_\_\_\_ other: \_\_\_\_\_

7. Date of diagnosis/diagnoses: \_\_\_\_\_

8. Was/were the diagnosis/diagnoses made by you?    \_\_\_\_\_ **Yes**    \_\_\_\_\_ **No, DX made by:**

9. Number of consultations with you in the past 3 years: \_\_\_\_\_
10. Date of your most recent evaluation: \_\_\_\_\_
11. Length of time under your care: \_\_\_\_\_
12. Currently under your care? \_\_\_\_\_ **Yes** \_\_\_\_\_ **No, care ended on:** \_\_\_\_\_
13. Medical/therapeutic equipment needed: \_\_\_\_\_
14. If applicable, indicate any medications currently prescribed that may impact the student's functioning, including any impact produced by side effects.
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
15. Please describe in detail the symptoms currently experienced by the student.
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
16. Please describe in detail how the disability interferes with one or more major life activities as would be encountered in the residential living environment. (*Attachments are welcome if additional space is needed.*)
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
17. Given the standard housing assignment and study locations explained on pg. 1, please describe and provide rationale for any modifications you are recommending to accommodate the student's disability.
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
18. Please also explain how the modifications you recommend would alleviate the functional limitations of the student's underlying condition.
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
19. If your recommendation is for the college to provide a single room accommodation, is this accommodation a medical necessity or simply beneficial? \_\_\_\_\_ **Medical necessity for student**  
\_\_\_\_\_ **Beneficial for student**
20. Please indicate what you and the student have discussed regarding current coping strategies for college:
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
21. What are some possible alternatives if meeting your primary recommendation is not possible?
- \_\_\_\_\_

---

---

22. Accommodations for this student's disability are recommended...

For several months.... How many?  For the duration of the student's time in college  
 For the next year only  Duration is unknown at this time

23. If you are recommending a single room, please indicate whether and how there are any risks associated with the student's isolation:

---

---

---

24.  I have attached supporting documentation for diagnosis/diagnoses. (See *Limestone University's Disability Provider Forms for Documentation.*)

*I understand that the information provided will become part of the student record subject to the Federal Family Education Rights and Privacy Act of 1974 and may be released to the student on their written request.*

Provider's Signature \_\_\_\_\_ Date \_\_\_\_\_

License/Certification # \_\_\_\_\_ State \_\_\_\_\_

Name/Title: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_

Email: \_\_\_\_\_

---

**DOCUMENTATION MAY BE SENT OR FAXED TO:**  
Limestone University  
Learning and Accessibility/Accommodations  
1115 College Drive  
Gaffney, SC 29340  
Email: [tlscott@limestone.edu](mailto:tlscott@limestone.edu)  
Fax: 864-203-8747