SIENA HEIGHTS UNIVERSITY

Office of Accessibility Intake Form

Name: _____ Student ID #: _____

Address: _____ Date of Birth: _____

City: _____ State: _____ Zip: _____ Primary Phone: _____

Email address: _____

SHU Student Email address: _____@student.sienaheights.edu

(All official communication will be sent to your student email account once you are accepted)

Emergency Contact: _____ Phone #: _____

Current Treating Professional (if any): _____

Address: _____

Phone #: _____ Fax #: _____

Therapist/Psychiatrist (if any): _____

Address: _____

Phone #: _____ Fax #: _____

Are you working with Vocational Rehabilitation (MRS, Bureau, etc.)? ☐Yes ☐No

Name of Counselor: _____ Phone: _____

I have read the SHU Documentation Requirements for Special Services/Accommodations and I understand that I must submit official documentation to verify my disability and receive services.

_____ _____

Student's Signature Date

For Office of Accessibility use only:

Intake Form: Received Date: _____ Received by: _____

Documentation: Received Date: _____ Received by: _____

SIENA HEIGHTS UNIVERSITY

Factors Impacting College Success

Student's Name:_____

Student ID#: _____

Phone: _____

Think about possible concerns as you take this journey to college success. Review the statements below and mark "X" that apply to you.

I am concerned about:

- ☐ Study Habits
- ☐ Note Taking Skills
- ☐ Test-Taking skills
- ☐ My reading skills
- ☐ My writing skills
- ☐ Experiencing test anxiety
- ☐ Time management
- ☐ Adjusting to a college routine
- ☐ My Career direction
- ☐ Asking for help

Challenges I have had

- ☐ Attending Class
- ☐ Goal Setting
- ☐ Checking Email
- ☐ Being academically motivated
- ☐ Disability/Accessibility related issues
- ☐ Difficulty learning specific course material: Please specify course name(s):
- ☐ Being unaware of resources available
- ☐ Inadequate balance between work schedule and classes and homework
- ☐ Inadequate balance between extracurricular activities and class work (such as athletics, clubs, organizations, etc.)
- ☐ Stress in my life
- ☐ Money management problems
- ☐ Financial challenges
- ☐ Academic Advising

- [ ] Problems with residence hall roommate
- [ ] Problems with off-campus roommate(s)
- [ ] Problems with relationships
- [ ] Personal issues
- [ ] Family issues
- [ ] Health issues
- [ ] Use of alcohol and/or drugs
- [ ] Working too many hours
- [ ] Transportation
- [ ] Other; please describe:

My top three concerns or challenges are:

1.

2.

3.

Please return this document at our first meeting.

Siena Heights University
Office of Accessibility
517-264-7683
Fax: 833-413-2849
accessibility@sienaheights.edu

HIPAA-Compliant Authorization
Release of Health & Education Information

I, _____, (*Date of Birth*) _____, authorize the Office of Accessibility at Siena Heights University and Cody Marie Mathis, Accessibility Coordinator to exchange health and/or education information/records with:

_____
(*insert Name, address & telephone of school/school district*)

_____
(*insert Name, address and telephone of health care provider*)

Description:

The health information to be disclosed consists of:

Nature of disability and impact on education/classroom setting and athletics participation

The education information to be disclosed consists of:

Psychological Evaluations, IEP/ETR Reports, 504 Plans, and/or any other documentation to assist in accommodations under ADA

Purpose: This information will be used for the following purpose(s):

Documentation of disability and history of accommodations provided in accordance with ADA and Section 504 and eligibility for accommodations at Siena Heights University. This information will assist in the determination of appropriate accommodations and services ongoing.

Authorization:

This authorization is valid for one calendar year. It will expire on _____. I understand that I may revoke this authorization at any time by submitting written notice of the withdrawal of my consent. I recognize that health records, once received by the University, may not be protected by the HIPAA Privacy Rule, but will become education records protected by the Family Educational Rights and Privacy Act.

_____ _____
Student Signature Date

Please fax requested information Attn: Cody Mathis to 833-413-2849 Thank you.

SIENA HEIGHTS UNIVERSITY

To Be Filled out by Stuent:

Student name: _____ Date of Birth: _____

SHU ID: _____

(Remainder of page -- To be completed by Mike Milller, Director of Chartwells Dining at SHU

Please indicate which accommodations can be provided by Chartwells at SHU Dining on a regular basis:

_____

- ☐ Access to the Gluten Free section (including baked goods, soups, sandwiches, etc)
- ☐ Access to the Dairy Free menu options
- ☐ Access to Vegetarian menu options (including seasonal/organic/local produce)
- ☐ Access to Vegan menu options (including seasonal/organic/local produce)
- ☐ Access to Kosher menu options
- ☐ Specialized diets for Gastrointestinal Diseases (e.g., Crohn's, Colitis, IBS)
- ☐ Specialized diets for Diabetes
- ☐ Menu planning consultation with Dining Services Staff
- ☐ Consultation with staff Nutritionist
- ☐ Bulk purchasing program
- ☐ Other (please describe the dietary access modification you believe is necessary):

☐ After meeting with _____ (student name) and discussing their dietary needs, I attest that the above accommodations can be made.

☐ After meeting with _____ (student name) and discussing their dietary needs, I attest that the above accommodations cannot be made.

Signature: _____ **Date:**_____ **Date of Student Meeting:** _____

Please return completed form to:

Cody Marie Mathis
Director of Accessibility
ADA Coordinator
cmathis1@sienaheights.edu

Tel: 517-264-7683
Fax: 833-413-2849

Siena Heights University
1247 East Siena Heights
Drive Univeristy Center 211
Adrian, MI 49221

SIENA HEIGHTS UNIVERSITY

Documentation for Dietary Accommodation Request

To Be Filled out by Stuent:

Student name: _____ Date of Birth: _____

SHU ID: _____

The student has requested the following accommodation/modification (filled out by student):

_____

_____

_____

(Remaining Pages -- To be completed by healthcare professional, who is NOT related to the student)

To be filled out by Provider:

Health Care Provider's Name: _____

Health Care Provider's credentials: _____

License or Certification Number: _____

Please note: Siena Heights University ensures equity for all students including equal access for students with disabilities. As a four-year residential college, learning to live in a community and share space with others is an integral part of students' educational experience. A standard meal plan for freshman includes a 19-meal plan (averaged out to 3 meals M-F, 2 Sa/Su), Sophmores/Juniors/Seniors in residence halls include either maintaing 19-meal plan or decreasing to a 14-meal plan (averaged out to 2 meals per day), and those living in CV get a75-meal plan (75 meals per semester).

Accommodations adjustments are made to facilitate equal access, they are not intended to ensure a preference or desired outcome. To establish a medical need for dietary accommodations, unless the disability and the disability-related need for the accommodation is obvious and apparent, documentation of the disability is required.

The student named above, as part of their residential requirement at Sienah Heights, is a residential student, per campus residence policy of 3-years (on Adrian campus only). When it is not obvious that an individual is disabled or requires a requested accommodation/modification, the Univeristy needs to verify the same. We appreciate your cooperation in answering the questions on this form and returning it as directed at the end of the form.

Please answer the following questions (please attach additional pages if space is required):

Definition of "Disabled"

Under federal law (ADA), for the purposes of public accommodations, an individual is disabled if he/she has a physical or mental impairment that substantially limits one or more major life activities; has a record of such an impairment; or is regarded as having such an impairment.

The term physical or mental impairment includes, but is not limited to, such diseases and conditions as orthopedic, visual, speech, and hearing impairments, cerebral palsy, autism, epilepsy, muscular dystrophy, multiple sclerosis, cancer, hearing disease, diabetes, Human Immunodeficiency Virus infection, intellectual or developmental disabilities, emotional illness, drug addiction, and alcoholism. This definition does not include any individual who is a drug addict and is currently using illegal drugs or an alcoholic who poses a direct threat to property or safety because of alcohol use.

The term major life activities means those activities that are of central importance to daily life, such as seeing, hearing, walking, breathing, performing manual tasks, caring for one's self, eating, learning and speaking.

Information Requested

1. Is the individual disabled as defined above? ◯ Yes ◯ No
    a. Is the individual currently under your care? ◯ Yes ◯ No
2. Does the student require medical/therapeutic equipment? ◯ Yes ◯ No

    If yes, please explain:

    _____

Using as much space as needed, please describe the type, severity, and frequency of symptoms currently experienced by the student, and how the disability interferes with eating or dining in university facilities.

_____

_____

_____

_____

- [ ] Life threatening/anaphylaxis (Student carries an epi-pen)
  - [ ] Due to airborne contact
  - [ ] Due to cross-contamination
  - [ ] Due to ingesting food, only
  - [ ] Other (please specify)
- [ ] High sensitivity, no anaphylaxis
  - [ ] Due to airborne contact
  - [ ] Due to cross-contamination
  - [ ] Due to ingesting food, only
  - [ ] Other (please specify)

Describe the requested meal plan accommodation. Please explain how the requested accommodation is necessary to allow equal access to the University's meal plan and facility.

In addition, mark all that apply.

- [ ] Gluten-free menu options
- [ ] Dairy and lactose-free options
- [ ] Vegetarian menu options
- [ ] Vegan menu options
- [ ] Access to Kosher menu options
- [ ] Specialized diets for gastrointestinal diseases (e.g. Chron's, Celiacs, Colitis, IBS, etc.)
- [ ] Other (please describe any modification(s) you believe are necessary; specify other food allergies, sensitivities and/or conditions)
- [ ] Exemption from meal plan

If applicable and not already provided, please provide a list of foods that must be avoided (categories) and/or foods that are acceptable (categories).

_____

_____

_____

_____

_____

What are the possible alternatives if meeting your primary recommendation is not possible?

_____

_____

_____

_____

_____

_____

Documentation will be kept in a confidential file available only to the members of the housing accommodation committee, whose recommendations are based on whether the medical documentation meets the above guidelines. The committee may seek additional information or clarification from the provider as needed.

Signature of Health Care Provider: _____ **Date:**_____

Please include a business card or official letterhead with documentation

Please return completed form to:

Cody Marie Mathis
Director of Accessibility
ADA Coordinator
cmathis1@sienaheights.edu

Tel: 517-264-7683
Fax: 833-413-2849

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