Housing Disability Verification Form – Contract Appeals

Accessible Housing - University of Waterloo
200 University Avenue West, Waterloo, ON N2L 3G1
Phone: 519-888-4567, ext. 42679
Email: accessiblehousing@uwaterloo.ca

Dear Practitioner,

Your patient is requesting an appeal to release themselves from being financially responsible for their residence contract. They are appealing on the grounds of a disability.

Our office requires that you have first-hand knowledge of the student's condition, experience in working with students with the stated condition(s), and a familiarity with how the living environment may impact the conditions' functional limitations. Information gathered by AccessAbility Services will be used to determine the impact of the student's disability for the purpose of absolving financial responsibility of their residence contract. Disability documentation submitted to AccessAbility Services is confidential and is retained in accordance with pertinent provincial and federal regulations.

Student Information (Please Print):	
Student's Last Name:	
Student's First Name:	
Date of Birth (DD/MM/YYYY):	
University of Waterloo ID#:	
Address: (Street #, City, Province and Postal Code)	
Phone Number (Home/Cell):	
E-mail Address:	

Student Consent

I give consent for the University of Waterloo AccessAbility Services to contact my medical practitioner to discuss the information provided in this document if necessary to clarify the information provided regarding functional restrictions and limitations.

Completion of this section is voluntary; however, if you elect not to provide your consent at this time and in the event that further information is required there may be delays in the assessment of the contract appeal.

Student's Signature:	Date Completed (DD/MM/YYYY):

Student's informed authorization for disclosure of information is obtained in accordance with the following sections of the Freedom of Information and Protection of Privacy Act. Sections 41.(1)(a), 41.(1)(b), and 41.(1)(c) allowing for the use of personal information and sections 42.(1)(b), -s.42(1)(c), and s.42(1)(d) allowing for the disclosure of personal information.

Section 1: Verification of Disability

***Criteria to determine disability*:** The student experiences functional limitations due to a condition that impairs the student's ability to perform daily activities necessary to live in student housing.

1. **Disability Verification:**
   - ☐ This student has or had a ***disability*** condition, as defined above.
   - ☐ The student ***does not meet the criteria for a disability*** diagnosis, as defined above.
   - ☐ The presence of a disability is ***inconclusive***. This student is being assessed to determine the presence of a disability.

2. **Disability Type:**
   - ☐ Mental Health Disability
   - ☐ ADHD
   - ☐ Autism Spectrum Disorder
   - ☐ Learning Disability
   - ☐ Low Vision, Blind
   - ☐ Medical Disability
   - ☐ Acquired Brain Injury
   - ☐ Other: _____
   - ☐ Deaf, Deafened, Hard of Hearing
   - ☐ Physical/Mobility Disability

3. **Disability Diagnosis:** _____
   Note: Please provide a clear diagnostic statement; avoiding such terms as "suggests" or "is indicative of". The provision of a specific diagnosis is voluntary.

4. **Disability Status:**

   - ☐ Permanent
     Onset of disabling symptoms (DD/MM/YYYY): _____
   - ☐ Temporary
     Onset of disabling symptoms (DD/MM/YYYY): _____
     Duration of disability (DD/MM/YYYY): _____

   Date of diagnosis (DD/MM/YYYY): _____

5. **Assessment Information:**
   Forms of assessment used to verify disability (please select all that apply):
   - ☐ Physical Tests
   - ☐ Medical Tests
   - ☐ Personal and Family History
   - ☐ Psycho-educational or Neuropsychological Testing
   - ☐ Objective Tests
   - ☐ Student Self Report
   - ☐ Structured or Unstructured Interviews with Student
   - ☐ Interviews with Other Persons (Parent, Teacher, Therapist)
   - ☐ Other (Specify): _____
   - ☐ Another Physician/Regulated Health Professional (Name):

   Length of time you have been treating the patent: _____

   Date of last clinical assessment (DD/MM/YYYY): _____

Section 2: Functional Limitations & Impact in Residence

List symptoms, severity and functional limitations of the disability condition on the student's overall functioning in residence?

Symptom & Severity:
Functional Limitation:
Symptom & Severity:
Functional Limitation:
Symptom & Severity:
Functional Limitation:

Section 3: Medically Extenuating Circumstances

Based on your assessment above, please indicate the following:

1. The student would be able to live in Waterloo Residence with their current accommodations:
   - ☐Yes
   - ☐ No
   - ☐ N/A
2. The student would be able to live in Waterloo Residence if appropriately accommodated (with modified accommodations):
   - ☐ Yes
   - ☐ No
3. It is not recommended that the student continue to live in Waterloo Residence as a result of a new extenuating circumstance (i.e., new condition, increased symptoms, hospitalization, etc), with or without accommodations:
   - ☐ Yes
   - ☐ No
4. The student can return to Waterloo Residence in the future with appropriate accommodations:
   - ☐ Yes
   - ☐ No

   If yes, please indicate expected date: _____

Please provide additional details to the choices above and include information on why accommodations offered through Waterloo Residences would not be able to support the student's disability related needs:

Certificate of Attending Health Care Practitioner

Documentation completed by a relative of the student will not be accepted due to professional and ethical considerations even when the relative is otherwise qualified to do so. The provider signing this form must be the same person answering the questions on the form above.	
Practitioner Name (Please print):	**Name of Practice/Clinic/Hospital**:
Practitioner Signature:	**Address**:
Practitioner License/Registration #:	**Phone #:** ( ) -
Affix card here or office stamp	**Fax #**: ( ) -
	Date Completed (DD/MM/YYYY):