SPECIAL HOUSING AND/OR DINING ARRANGEMENT – STUDENT INFORMATION

As an NIU student with a documented medical condition, you may be eligible for a special room and/or board arrangement in NIU residence halls. At the request of Housing and Dining, NIU Health Services reviews medical information submitted by your licensed healthcare provider to confirm the presence of a medical condition requiring a special housing or dining arrangement. The information below is intended to assist you with a request for a special housing/dining arrangement and to avoid delays in the medical review process.

- You must contact NIU Housing and Dining in Neptune East (815-753-1525) regarding a request for a special housing and/or dining arrangement.

- If your medical condition requires a special diet, you must first consult with Residential Dining (815-753-0561) regarding the accommodation of your dietary needs by residence hall dining services. Review of your medical information will not be undertaken by Health Services if Residential Dining is able to meet the specific diet required by your medical condition.

- If medical review of your health information is indicated, a completed Student Application and Authorization – Special Housing and/or Dining Arrangement (below) must be submitted to Health Services Administration, Health Service Building, Room 422. This will confirm the nature of your request and permit Health Services to communicate with Housing and Dining regarding the status of the medical review.

- You must arrange for your licensed healthcare provider to submit medical information to Health Services to document the medical condition and the requirement for a special housing and/or dining arrangement. Two documents below, e.g., Licensed Provider Information and Licensed Provider Documentation Form, must be used for this purpose. Original, signed documents must be received by Health Services before medical review can begin. Faxed or photocopied documents will not be accepted.

- The Health Services administrative physician will review all medical documentation that has been submitted in support of your request for a special housing and/or dining arrangement. Medical review will be completed approximately one week following receipt by Health Services of your medical information.

- If the medical information documents a serious medical condition that requires a special housing and/or dining arrangement, a recommendation in favor of such an arrangement will be forwarded to NIU Housing and Dining where a final decision will be made for your request.

- If the medical information does not document a serious medical condition that requires a special housing and/or dining arrangement, Health Services will notify you by letter of this determination. You may submit additional, new medical information for administrative physician review.

Please call Health Services Administration (815-753-1316 or 815-753-1314), 8 AM – 4:30 PM, Monday – Friday, with any questions pertaining to the medical review process.
STUDENT APPLICATION AND AUTHORIZATION
SPECIAL HOUSING and/or DINING ARRANGEMENT

I am seeking a special housing and/or dining arrangement due to medical reasons during the semester indicated below.

Name ____________________________________________ SSN ______________________

Address _____________________________________________________________________

City _________________________________ State ____________ Zip Code ______________

Current daytime telephone number ___________________________ Date of birth __________

Beginning (circle one):         Fall      Spring       Summer     Interim          Year _______________

Specific request:

___ Single room
___ Release from residence hall contract (room and board)
___ Release from board contract (meal plan only)
___ Other______________________________________________________________

I HEREBY REQUEST AND AUTHORIZE the administrative physician or physician designee of Health Services, Northern Illinois University, DeKalb, IL 60115, to verify the presence of a medical condition that warrants a special housing and/or dining arrangement to the Executive Director for Housing and Dining, Neptune East, Northern Illinois University.

I understand that I have the right to inspect and/or obtain a copy of the information prior to disclosure and that my refusal to authorize disclosure of this information will result in the following consequences: Denial of my request for a special housing and/or dining arrangement.

I may revoke this authorization at any time by written notification to Health Services. However, I understand revocation cannot be retroactive. I absolve and agree to hold harmless the individual or agency identified above, and the NIU Board of Trustees, together with its officers and employees, from any legal liability, claims or damages which may arise from the disclosure of this information. Unless revoked, this consent is valid until the request is completely processed.

Signature of applicant        Date        Witness        Date

Return completed form to Health Services Administration, Health Service Building, Room 422.
LICENSING PROVIDER INFORMATION
SPECIAL HOUSING and/or DINING ARRANGEMENT

"Provider" means Licensed Healthcare Provider (e.g., MD, DO, Clinical Psychologist, etc.).

A student at Northern Illinois University (NIU) has applied for a special housing and/or dining arrangement due to a medical condition and has designated your office as a source of pertinent medical information to support his/her request. The process for requesting a special housing and/or dining arrangement for medical reasons involves review of the student’s pertinent medical information by the administrative physician at NIU Health Services.

• Pertinent medical information for this process includes written provider documentation of objective data (e.g., evaluation results, diagnosis, treatment recommendations, therapy, or other objective information) that documents a serious medical condition requiring a special room and/or board arrangement for the student.

• The student is solely responsible for arranging the release of pertinent medical information from your office to Health Services to support his/her application for a special housing and/or dining arrangement at NIU.

• Your patient will ask you to submit a completed Licensed Provider Documentation Form – Special Housing and/or Dining Arrangement to Health Services Administration, Health Service Building, Room 422. Please note the following:

  An original, signed licensed provider documentation form must be received by Health Services. Faxed or photocopied documents will not be accepted.

  Please return the original licensed provider documentation form only to Health Services. No other NIU office participates in reviewing the student’s medical information.

  Only the information indicated on the licensed provider documentation form is requested at this time. Please do not send copies of your patient’s medical records to Health Services or to any other NIU office.

This medical documentation is being requested for Health Services administrative purposes only, not for treatment, payment or other operational purpose. The documentation will be maintained confidentially at Health Services in a secure location separate from the student’s medical record for a period of ten years from the date of the student’s last NIU enrollment and then destroyed.

Please call Health Services Administration (815-753-1316 or 815-753-1314), 8 AM - 4:30 PM, Monday – Friday, with any questions pertaining to the medical review process.

Thank you.
### LICENSED PROVIDER DOCUMENTATION FORM

**SPECIAL HOUSING and/or DINING ARRANGEMENT**

<table>
<thead>
<tr>
<th>Student’s Full Name ____________________________</th>
<th>SSN __________________</th>
</tr>
</thead>
<tbody>
<tr>
<td>Semester and Year of Request____________________</td>
<td>DOB __________________</td>
</tr>
</tbody>
</table>

**Air-conditioning in residence halls is available until approximately mid-September on a limited basis.**

For additional information see [Licensed Provider Information – Special Housing and/or Dining Arrangement](http://www.niu.edu/uhs/pdfs/shda.pdf).

Please type or print the requested information in the space provided and return this form to Health Services Administration, Health Service Building, Room 422, DeKalb, IL 60115. Thank you.

<table>
<thead>
<tr>
<th>1. Diagnosis and code of the severe medical condition that requires a special housing and/or dining arrangement.</th>
</tr>
</thead>
<tbody>
<tr>
<td>2. For the above condition, indicate:</td>
</tr>
<tr>
<td>▪ All date(s) of evaluation and/or treatment during the past six months;</td>
</tr>
<tr>
<td>▪ Location of evaluation and/or treatment(s) (e.g., office, hospital OP, hospital IP, etc.); and</td>
</tr>
<tr>
<td>▪ Nature/purpose of evaluation and/or treatment(s) provided.</td>
</tr>
<tr>
<td>3. Specific medical findings, restrictions or other objective data that require a special housing and/or dining arrangement for your patient.</td>
</tr>
</tbody>
</table>

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Signature of Attending Licensed Healthcare Provider and Title ____________________________ Date __________

Printed Name, Business Address, Telephone Number ________________________________________________________________________________
Authorization for Release of Confidential Health Information
for Administrative Purpose

Name: ___________________________ (Last) ___________________________ (First)

SSN ___ / ___ / ______ Date of Birth ___ / ___ / ______ Phone# (___ ) ______

Address ___________________________ City ___________________________ State ___ Zip

I, the above named patient, authorize NIU Health Services to release my confidential health information to the Health Services Administrative Physician for the purpose of administrative review of my request for a Medical Withdrawal, Course Load Reduction or Special Housing/Dining Arrangement at Northern Illinois University.

Please list the names of the NIU Health Services Practitioners and staff authorized by this release:

______________________________
______________________________

Please indicate information and dates to be released:

☐ Immunizations ___________________________ ☐ Lab results ___________________________

☐ Office visit notes ___________________________ ☐ X-ray results or film ___________________________

☐ Other ____________________________________________

Diagnosis of Mental Health, Alcohol and Substance Abuse and Infectious Disease (AIDS/HIV) are NOT included in a general release. Federal regulations outlined in the Code of Federal Regulations, 42 CFR, Ch. 1, Part 2 (1983), and Illinois 740 ILCS 110 require diagnosis of Mental Health, Alcohol and Substance Abuse and Infectious Disease information specifically indicated. Please indicate information and specify dates to be released and initial.

☐ Mental Health __________  ☐ Alcohol and Substance Abuse __________  ☐ Infectious Disease __________

I understand that I have the right to inspect and/or obtain a copy, for an appropriate fee, of the information prior to disclosure. I may revoke this authorization at any time, except to the extent that action has already been taken, by submitting a written revocation to Northern Illinois University, Health Services. If I refuse to sign this authorization, my medical record/information will not be released. This authorization will be considered valid for a 90-day period (expiration date ___ / ___ / ___) following the date of signature unless otherwise specified here. I absolve the individual or agency identified above and the Board of Trustees of Northern Illinois University together with its officers and employees from any legal liability which may arise from the disclosure of this information.

Patient Signature: ___________________________ Date: ____________

Witness Signature: ___________________________ Date: ____________

NOTICE TO RECEIVING AGENCY/PERSOR: Under the provisions of the Illinois Mental Health and Developmental Disabilities Confidentiality Act, you may not redisclose any of this information unless the person who consented to this disclosure specifically consents to such redisclosure. Under the Federal Act of July 1, 1975, Confidentiality of Alcohol and Drug Abuse Patient Records, no such records, nor information from such records, may be further disclosed without patient authorization for such disclosure.

Processed by ___________________________ Date Processed ________