Office of Disability Services

MEAL PLAN ACCOMMODATION REQUEST FORM

21000 West Ten Mile Road C405
Southfield, MI 48075
Phone: 248.204.4100
Fax: 248.204.4115
Email: disability@ltu.edu

Lawrence Technological University (LTU) is deeply committed to the full participation of students with disabilities in all aspects of college life, including residential life. In accordance with Section 504 of the Rehabilitation Act and the Americans with Disabilities Act (ADA), LTU has established procedures to ensure that students with documented disabilities receive housing assignments that meet their needs as required by law.

The documentation below will determine whether the student has a condition or combination of conditions that constitute a disability, and whether the disability causes limitation for which the student needs reasonable accommodation(s). Documentation will assist the Office of Disability Services in understanding how the disability impacts the student in the Blue Devil Cafe and the current impact of the condition(s) as it relates to the meal plan request. This form, and all relevant information, must be completed or provided by an appropriate qualified medical professional. All documentation and subsequent accommodations will be evaluated on a case by case basis.

STUDENT INFORMATION (TO BE COMPLETED BY THESTUDENT):

Name: _____ Banner ID: _____

Address: _____ LTU Email: _____

City: _____State: _____ Zip: _____

Cell Phone: _____ Home Phone: _____

Student Signature: _____ Date: _____

AUTHORIZATION TO RELEASE INFORMATION:

I authorize the provider listed below to release information related to my request to Lawrence Technological University's Office of Disability Services for the purpose of an accommodation to my meal plan and to discuss this request with a staff member of LTU.

Name of Medical Provider: _____

Address: _____

City: _____ State: _____ Zip: _____

Student Signature: _____ Date: _____

STUDENT INFORMATION (TO BE COMPLETED BY THESTUDENT):

If a request is based on a disability or medical condition* that implies the student will work with the Office of Disability Services. The student will register with the Office of Disability Services by providing appropriate documentation supporting the need for accommodations. The Office of Disability Services will then decide on whether the request is approved and thus any appropriate accommodations will be established.

If a request is based on dietary or religious preferences, please contact Dining Services at campusdining@ltu.edu to schedule a meeting with our Dining Services Chef or designee to discuss and review all of our menu options, ingredients, or cooking methods. The goal of this process is to provide student with the knowledge and tools they need to be active in the management of their diet.

If a request is based on the economics of the student, please email the Housing Office at housing@ltu.edu. *Please be aware that in the rare instance Dining Services cannot meet your nutritional or medical needs, an exemption may be considered, but will not be granted on the basis of dietary preferences or financial reasons. All requests are determined on a case by case basis.

Is your meal plan accommodation request related to a medical issue or disability? ☐ Yes ☐ No

STUDENT INFORMATION (TO BE COMPLETED BY THESTUDENT):

AUTHORIZATION TO RELEASE INFORMATION:

I authorize the Office of Disability Services to disclose this completed form to Campus Dining, so that they may review the information before meeting. I understand that meeting with the Manager of Campus Dining is part of the process to request a meal plan reduction.

Student Signature: _____ Date: _____

MEDICAL VERIFICATION: TO BE COMPLETED BY HEALTHCARE PROVIDER

A patient at your practice is a student at Lawrence Technological University and is requesting meal plan accommodations. Part of the process of requesting meal plan accommodations is submission of current medical documentation that provides insight into the student's condition, its impact on their ability to participate in the meal plan and dining services, and recommended accommodations. **Please complete this section in full.** If additional space is needed, please attach additional documentation.

Section I: Patient Information

Patient's Name: _____ DOB: _____

Diagnosis/Condition: _____

ICD-10 or DSM-V Code(s): _____

Date of diagnosis: _____

The condition is: ☐ Permanent ☐ Episodic ☐ Temporary

What is the severity of the condition? _____

When did you last see the student? _____

Is the student a current patient under your care? _____

List any prescription medications: _____

Section II: Definition of Disability

The Office of Disability Services provides reasonable accommodations to students with diagnosed disabilities. A disability is defined under the Americans with Disabilities Act as "a physical or mental impairment that substantially limits one or more major life activities."

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, heart 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, learning and speaking.

Is the student disabled as defined above? ☐ Yes ☐ No

Does the student require medical/therapeutic equipment? ☐ Yes □ No

CONTINUED: MEDICAL VERIFICATION: TO BE COMPLETED BY HEALTHCARE PROVIDER

Section III: Accommodation Recommendations

What is the impact and severity (mild/moderate/severe) of this condition as it relates to encounters in a Dining Services environment? Please describe in detail how the disability interferes with eating in a Dining Hall.

_____

_____

_____

_____

_____

Please list the types of food the student is to avoid (cannot eat) with corresponding severity of reaction. Please attach a separate sheet if more space is required.

_____

_____

_____

_____

_____

Please list the diet/diets that the student should follow, including a sampling of foods the student can eat. Please attach a separate sheet if more space is required.

_____

_____

_____

_____

_____

Additional information/comments: _____

_____

_____

_____

CONTINUED: MEDICAL VERIFICATION: TO BE COMPLETED BY HEALTHCARE PROVIDER

Healthcare Provider's Name: _____

Title: _____

Area of Specialty: _____

Type of License: _____

State of License: _____License Number: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone Number: _____ Fax Number: _____

My signature verifies that I am or have been this student's treating health care professional and that all the contents above are true and accurate.

Signature: _____ Date: _____

PLEASE RETURN THE COMPLETED FORM TO:

The form can be turned in by mail, email or in person.

The Office of Disability Services, C405
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