ACCESS NEEDS IN RESIDENCE

“The University of Toronto respects your privacy. The information on this form is collected pursuant to section 2(14) of the University of Toronto Act, 1971. It is collected for the purpose of administering admission, registration, academic programs, university-related student activities, activities of student societies, financial assistance and awards, graduation and university advancement, and for the purpose of statistical reporting to government agencies. At all times it will be protected in accordance with the Freedom of Information and Protection of Privacy Act. If you have questions, please refer to www.utoronto.ca/privacy or contact the University Freedom of Information and Protection of Privacy Office at 416-946-7303, McMurrich Building, room 201, 12 Queen's Park Crescent West, Toronto, ON M5S 1A8.”

In order to determine how best to support your needs and determine the best housing options available to you while living in residence, we ask that you please complete the following self-report to the best of your ability. All of the information you provide is kept confidential, however, feel free to leave any questions blank that you do not feel comfortable answering. If you require additional space to record information, please attach additional paper to this form.
STUDENT INFORMATION

Name: __________________________ Student Number: __________________________
Address: ________________________________________________________________
Home Telephone: __________________________________________________________
Alternate Telephone (☐ cell ☐ pager ☐ work): ________________________________
Email: ________________________________________________________________
Language: ☐ English ☐ French ☐ Sign Language (ASL/LSQ)
Have you lived in residence at the University of Toronto Scarborough before?
☐ Yes ☐ No
If yes, did your housing placement meet your needs?
☐ Yes ☐ No
If not, please explain: _________________________________
                                   _________________________________
                                   _________________________________
Emergency Contact Person
Name: __________________________ Relationship: __________________________
Address: ________________________________________________________________
Telephone: ________________________________________________________________
NATURE OF DISABILITY

Please check all that apply that you feel comfortable disclosing:

☐ Acquired Brain Injury  ☐ Attention Deficit/Hyperactivity Disorder
☐ Chronic Medical  ☐ Deaf, deaf, Deafened, Hard-of-Hearing
☐ Learning Disability  ☐ Low Vision, Blind
☐ Mobility/Functional  ☐ Psychiatric

☐ Other: _____________________________________________________________

Nature of Condition: _________________________________________________
How long have you had this condition?: _________________________________

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If you have indicated the nature of your disability as Psychiatric, do you have specific requirements that need to be considered for your housing/room assignment? If yes, please specify below:

_____________________________________________________________________
_____________________________________________________________________
_____________________________________________________________________
_____________________________________________________________________
_____________________________________________________________________
_____________________________________________________________________

If you have a Seizure Disorder, please specify the type of support you require during an episode.

_____________________________________________________________________
_____________________________________________________________________
_____________________________________________________________________
_____________________________________________________________________
_____________________________________________________________________
Do you have any allergies that need to be considered for your housing/room assignment? If yes, please specify below:

Dietary
Please specify: __________________________________________

Medication
Please specify: __________________________________________

Environmental
Please specify: __________________________________________

Please specify what accommodations are required based on your allergies.

________________________________________
________________________________________
________________________________________
________________________________________

Medication(s)
For emergency purposes, it may be useful to have a list of your prescribed medication and the known side-effects:

□ N/A

Brand/Generic Name: ________________________________
Classification: ________________________________
Side effect(s): ________________________________

Brand/Generic Name: ________________________________
Classification: ________________________________
Side effect(s): ________________________________

Brand/Generic Name: ________________________________
Classification: ________________________________
Side effect(s): ________________________________

Brand/Generic Name: ________________________________
Classification: ________________________________
Side effect(s): ________________________________
GENERAL INFORMATION

Mobility and Transportation
Can you use stairs? □ Yes □ No
Do you require an automatic door opener? □ Yes □ No
If you use mobility aids, please indicate your reach range (in cm):
   Forward reach: ____________ Side reach: ____________
Will you bring your own vehicle? □ Yes □ No
Do you have a Ministry Accessible Parking permit? □ Yes □ No
Will you be using Wheel Trans? □ Yes □ No

Kitchen
If you use mobility aids, please indicate height specifications for (in cm):
   Sink: _________ Stove: _________ Countertops: _________ Switches: _________
Do you require a mirror above the stove? □ Yes □ No
Do you require electrical outlets at the front of the counter? □ Yes □ No

Washroom
Do you need a house with two washrooms? □ Yes □ No
Do you need a bedroom close to the washrooms? □ Yes □ No
Do you require a fully accessible washroom? □ Yes □ No
   (minimum turning radius, level access, roll-in shower stall, grab bars, hand held shower head, lever handles, etc.)
If you do not need a fully accessible washroom, what are your needs in terms of washroom access?
____________________________________________________
____________________________________________________
____________________________________________________
____________________________________________________
____________________________________________________
____________________________________________________
____________________________________________________
____________________________________________________
____________________________________________________
Bedroom
Do you require a single room? □Yes □No
Do you require a protective mattress cover? □Yes □No
If yes, does the cover need to be waterproof? □Yes □No
What type of mattress do you require?
□Longer than average: (specify length in cm):
□Wider than average: (specify width in cm):
Do you require furniture to be at a specific height? □Yes □No
Indicate height of bed from floor (in cm):
Indicate height of study table (in cm):
Indicate width of opening at study table (in cm):
Indicate any other needs in terms of furniture specification:

Attendant Service
Note: UTSC does not arrange for the provision of personal care attendant services.

Will one of the following services be providing you with Personal Care while you are living in residence?
□Attendant Service
□Nursing Service
□Other professional, please specify:

Will the service require parking? □Yes □No

Please indicate your Average Daily level of service required (choose only one):
□Less than 1.5 hours
□1.5 to 3 hours
□3 to 5 hours
□5 to 7 hours
□Greater than 7 hours
□Other, please specify:
Emergency Plan

Do you need assistance during an emergency evacuation? □Yes □No

If yes, please indicate the specific assistance you will need (e.g. getting out of bed, carrying equipment, toileting, etc.):

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

Of the assistive devices and/or medical equipment that you are bringing with you, what would you need to take with you in the event you are required to evacuate your residence room or apartment for up to 72 hours?

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

EVACUATION DISCLOSURE STATEMENT

I give consent to Student Housing & Residence Life to share information with Housing staff and the university Emergency Response team with respect to my above stated evacuation plan.

Signature: ___________________________ Date: ___________________________

Communication

Can you communicate verbally? □Yes □No

Do you use assistive devices to communicate (i.e. TTY)? □Yes □No

Do you require the assistance of other communication aids? □Yes □No

If yes, please specify:

________________________________________________________________________

Vision/Lighting

Do you use Braille? □Yes □No

Do you require task lamps? □Yes □No
Other
Do you require a portable visual doorbell? □Yes □No
Do you require a portable fire alarm device? □Yes □No
Do you have a service animal? □Yes □No

If yes, please describe the requirements for accommodating the needs of the animal:

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

SPACE REQUIREMENT

The following three (3) sections provide an opportunity to tell us what devices, technology and aids you will bring with you to residence. This will help us to better understand the space requirements you will need. Please check all that apply to you.

Assistive Devices That You Will Bring
□ Walking Aids □Electric Wheelchair □Manual Wheelchair
□Walker □Scooter □Commode
□Bath chair/stool □Transfer bath bench □Raised toilet seat
□CPAP machine □Ventilator □Portable Hoyer Lift
□Hospital bed

Other: ____________________________________________________________
________________________________________________________________________

Equipment That You Will Bring
□Computer □Large Screen monitor □Scanner
□Visual doorbell □Visual fire alarm □Footrest
□Adjustable chair □Task lighting □Voice recognition software

Other: ____________________________________________________________________________
________________________________________________________________________
**Note:** You may have access to a bathtub transfer bench, raised toilet seat, and visual signaling devices for your use should you need them. Please speak to our staff to ensure the aids are available and will meet your needs.

**ADDITIONAL COMMENTS**

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

Please provide any medical documentation that may assist in determining your needs in residence.
Student Housing and Residence Life and AccessAbility Services

Mutual Exchange of Information Form
Consent to the disclosure/transmittal or examination of records or information

Name: ________________________________

Address: ________________________________

DOB: ___________ Student #: ___________

I, ___________________________ hereby give consent to Student Housing & Residence Life and AccessAbility Services at the University of Toronto Scarborough to exchange the following specified information about me, either orally or in writing. They may only exchange information related to my disability and/or accommodations that they consider relevant to the determination and arrangement of appropriate residence accommodations that will assist me in my academic pursuits at the University of Toronto Scarborough.

I am also aware that, should building modifications be required, my needs will be shared with the Maintenance Staff, but the nature of my disability will not be shared.

I understand that this information will be shared for professional use only, and that the privacy and confidentiality of this information will be protected and maintained at all times.

I understanding that this authorization is valid for one year from the date it is signed. I also understand that I may rescind or amend this authorization to Student Housing & Residence Life and/or AccessAbility Services at any time prior to the expiration of this consent, except where action has already been taken with respect to the authorization.

Signature: ___________________________ Date: ___________________________