Meal Plan Accommodation Request Form

Disability Services
4400 University Drive, MS 5C9, Fairfax, Virginia 22030
Student Union Building I (SUB I), Suite 2500
Phone: 703-993-2474 | Fax: 703-993-4306
Email: ods@gmu.edu | Website: http://ds.gmu.edu

Dear Student,

In an effort to effectively respond to student disability-related requests for meal plan modifications and accommodations, George Mason University has created the Meal Plan Committee. Each request will be handled on a case-by-case basis and is reviewed by the Meal Plan Committee where staff from Disability Services consult with the Campus Dietitian, the Mason Card Office, and Dining. Any documentation submitted to support a request should be current and relevant and be from an appropriate professional that describes the current functional impact of the condition or disability as it relates to a meal plan modification or accommodation requested. The Meal Plan Committee will discuss reasonable modifications or accommodations based on student self-report, staff observations, and documentation.

Mason reserves the right to request additional documentation if the information submitted appears to be outdated, inadequate in scope or content, does not address current level of functioning, or does not substantiate a need for modifications or accommodations. Disability Services will make a determination following the Special Meal Plan Committee's review of student requests. Disability Services will contact students directly via Mason email account to communicate that determination. Students who are not satisfied with the outcome of their meal plan accommodation request are encouraged to review the Disability Services Grievance Process (https://ds.gmu.edu/grievances/).

There are two parts to the meal plan accommodation process:

Part 1: Completion and submission of this application and the Disability Services Student Intake Form to Disability Services. Once received, the student will meet with a Disability Services Specialist for an initial intake meeting to discuss the request.

Part 2: Meet with the Campus Dietitian. The Campus Dietitian will work through individual situation/concerns to determine if/how the university can accommodate the student in the dining halls.

Once both parts have been completed and the Meal Plan Committee has reviewed the request, Disability Services will communicate the outcome of the request via Mason email. The Completed by Student section of this form will be shared with Campus Dining, the Campus Dietitian, and the Mason Card Office.

To begin the process, please complete the attached form with your healthcare provider/professional and return it to Disability Services using the contact information below at your earliest convenience. Questions about the meal plan accommodation process may be directed to Disability Services at ods@gmu.edu or by contacting Disability Services by phone (703) 993-2474.

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Additional Information

University Policy and Meal Plan Options

University policy requires that students living on campus in housing without a full kitchen in their room have a residential meal plan. Students living in a residential space with a full kitchen in their room are not required to have a residential meal plan. **Meal plan requirements/options** are as follows:

Independence Meal Plan

- Freshmen – having earned less than 30 credit hours
- Sophomore – having earned between 30 and 59 credit hours

Liberty 9 | Liberty 14 | Independence

- Junior – earned between 60 and 89 credit hours
- Senior – having earned 90 credit hours

RAs – must select Liberty 14 or Independence per contract

- All receive $1,000 meal plan discount
- Discount will be forfeited should meal plan exemption be granted
- The discount cannot be applied towards Freedom or Bonus funds
- Discount cannot be greater than the base meal plan price

Contact Information

Disability Services
Student Union Building I, Room 2500
4400 University Drive, MSN 5C9
Fairfax, VA 22030
Phone: (703) 993-2474
Fax: (703) 993-4306

Mason Card Office
Student Union I, Room 1203
4400 University Drive, MSN 5A5
Fairfax, VA 22030
Voice (703) 993-2870
Email: masonid@gmu.edu

Veronica Hayes
Registered Dietitian, Mason Dining
3108 The Hub, MSN 2F8
4400 University Drive
Fairfax, VA 22030
Voice (703) 993-3283
Fax (703) 997-8650
Email: vhayes@gmu.edu
Email: Veronica.Hayes@sodexo.com

To Be Completed by Student

Return this completed document directly to Disability Services. Your signature below indicates that you have read and understand the application and request process completely. Additionally, permission is given to physically share the To Be Completed by Student section with the members of the Special Meal Plan Committee, including: Mason Card Office, Disability Services, and Mason Dining.

Student Information
(Please Print Legibly or Type Directly into Form)

Name: _____

G#: _____

Status: ☐ Current Student ☐ Transfer Student ☐ Prospective Student

Phone: _____ Cell Phone: _____

Address (Street, City, State, Zip Code): _____

_____

Mason Email Address: _____@masonlive.gmu.edu

Personal Email Address: _____

This meal plan request is for: ☐ Fall ☐ Spring ☐ Summer Year: _____

Current Academic Level:
☐ Incoming Freshman
☐ Freshman
☐ Sophomore
☐ Junior
☐ Senior

Are you a transfer student? ☐ Yes ☐ No

Credit hours earned: _____

Current meal plan: _____

Reduce meal plan: ☐ Drop meal plan: ☐

Personal Statement (required):

Explain why a meal plan reduction/exemption is required. Clearly state how meals will be provided if not eating in the dining halls.

To be complete, requests must include your signature affirming agreement and clear responses to the items above. Students seeking meal plan modifications or accommodations are encouraged to return a completed Meal Plan Accommodation Request Form to Disability Services as soon as possible.

The signature below indicates that you agree that any information relevant to this request may be reviewed by appropriate University staff in evaluation and in any subsequent provision of accommodations.

Student's Signature: _____ Date: _____

To Be Completed by Healthcare Professional

Provide information addressing the separate items listed below by filling out this form. Additionally, permission is given to Disability Services to verbally share the To Be Completed by Healthcare Professional section with members of the Special Meal Plan Committee. You may also provide a printed narrative on your official letterhead. If using this form, please complete as thoroughly as possible. Inadequate information, incomplete answers, and/or illegible handwriting may delay the eligibility review process by necessitating follow-up contact for clarification. If a comprehensive diagnostic report is available that provides the requested information, copies of that report can be submitted for documentation instead of this form. Please provide a narrative report that explains the results if submitting case notes or rating scales.

Student Name: _____

Date last seen: _____

Impairment/Diagnosis (If applicable, include date of diagnosis and DSM-5/ICD-10 codes):

Relevant patient/client history:

Additional psychosocial and contextual factors:

How would you categorize this condition in terms of severity? Please check only one and explain below.

□ Minimal □ Moderate □ Severe □ Residual/Remission □ Other: _____

The condition is: ❑ Stable ❑ Prone to exacerbation ❑ Other: _____

Duration of impairment/diagnosis is: ❑ Permanent ❑ Temporary

Note Duration: _____ **or** Re-Evaluation Date: _____

Indicate major life activities that are affected because of the impairment and severity of those limitations. This list is not exhaustive and additional life activities can be added at the bottom of this chart.

Life Activity	Negligible	Moderate	Substantial	Don't Know	N/A
Breathing	❑	❑	❑	❑	❑
Concentrating	❑	❑	❑	❑	❑
Eating	❑	❑	❑	❑	❑
Emotional Processes	❑	❑	❑	❑	❑
Hearing	❑	❑	❑	❑	❑
Keeping Appointments	❑	❑	❑	❑	❑
Learning	❑	❑	❑	❑	❑
Lifting	❑	❑	❑	❑	❑
Managing External Distractions	❑	❑	❑	❑	❑
Managing Internal Distractions	❑	❑	❑	❑	❑
Manual Tasks	❑	❑	❑	❑	❑
Memory	❑	❑	❑	❑	❑
Organization	❑	❑	❑	❑	❑
Regular Attendance	❑	❑	❑	❑	❑
Seeing	❑	❑	❑	❑	❑
Self-Care	❑	❑	❑	❑	❑
Sitting	❑	❑	❑	❑	❑
Sleeping	❑	❑	❑	❑	❑
Social Interactions	❑	❑	❑	❑	❑
Speaking	❑	❑	❑	❑	❑
Stamina	❑	❑	❑	❑	❑

Life Activity	Negligible	Moderate	Substantial	Don't Know	N/A
Stress Management	❑	❑	❑	❑	❑
Studying	❑	❑	❑	❑	❑
Taking Notes	❑	❑	❑	❑	❑
Taking Tests	❑	❑	❑	❑	❑
Thinking	❑	❑	❑	❑	❑
Walking	❑	❑	❑	❑	❑
Writing	❑	❑	❑	❑	❑
Other: _____	❑	❑	❑	❑	❑

If applicable, list any medications, treatments, and assistive services/devices currently prescribed:

Please describe the anticipated progression or stability of the impact of the condition or disability over time, particularly the next 5 years:

The condition or disability described above is:

❑ Permanent/Chronic ❑ Long-term (6-12 mo.) ❑ Short-term/Temporary (6 mo. or less)

Please list any recommendations for meal plan modifications or accommodations and indicate how these modifications of accommodations would mitigate the substantial functional impact of the condition or disability. If relevant, you may also choose to address issues concerning impact on academic performance, social, an emotional well-being as well as the relationship of recommendations to the treatment plan and any negative impact that might result if accommodations are not provided. Use additional sheets as needed.

I understand that the information provided will become part of the student record subject to the Federal Family Education Rights and Privacy Act of 1974 and may be released to the student on their written request.

Healthcare Professional Signature: _____ Date: _____

Healthcare Professional Name (Print): _____

Title: _____

License or Certification #: _____

Address:

Phone: _____ Fax Number: _____

Email Address: _____