



Student Accessibility Services
1 John Carroll Blvd.
University Heights, Ohio 44118
Phone: (216) 397-4967
Fax: (216) 397-1820
Email: sas@jcu.edu

Disability-Related Housing Accommodations Request Form

All requests for housing accommodations for students with disabilities will be reviewed by the Housing Accommodation Committee. Students must provide documentation that indicates a diagnosed impairment that is a current substantial limitation to a major life activity as it relates to housing. If this is a new request, please provide current and comprehensive documentation of the disorder from a current treatment/assessment professional that is qualified to make the diagnosis. The Office of Residence Life will determine an appropriate housing assignment based on accommodation approval and availability in housing vacancies. Student Accessibility Services reserves the right to request additional documentation if necessary in order to provide appropriate services.

To request housing accommodations for the first time, Part I must be completed by the student and Part II must be completed by a current treatment/assessment professional. To renew a housing accommodation request, only Part I must be completed by the student. Please complete the necessary part(s) of this form in its entirety.

Upon completion, please submit to:

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This request form must be submitted each year according to housing deadlines in order to review and renew (as appropriate) accommodations provided through Residence Life.

If you have any questions about housing contracts or deadlines, please contact Residence Life at (216) 397-4408.

If you have any questions regarding available accommodations, please contact Student Accessibility Services at (216) 397-4967.



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PART I: TO BE COMPLETED BY STUDENT

Name: _____ Date of Birth: _____

Student ID: _____ Email: _____

Home Phone: _____ Cell Phone: _____

Home Address: _____

I am requesting accommodations for the following semester/year (check all that apply):

Spring 2021 _____ Fall 2021 _____ Spring 2022 _____

A. This is a:

_____ **New Request**

1. Student requesting housing accommodation must complete Part I of the Housing Accommodations Request Form.
2. Student’s current treatment/assessment professional, that is qualified to make the diagnosis and recommend housing accommodations, must complete Part II of the Housing Accommodations Request Form.

_____ **Renewal of a previous request**

1. Student requesting housing accommodation must complete Part I of the Housing Accommodations Request Form.
2. Unless there has been a change in student’s diagnosis or housing accommodation request, part II does not need to be completed for renewal of a previous request.

B. Campus Involvement

1. Are you a member of Greek Life or any other campus organization that has a living/learning component? ____ yes ____ no

If yes, please provide the name of the organization:

C. Previous Housing Assignments

1. To what residence hall were you assigned freshman year? _____
2. Was your room assignment freshman year single or double occupancy? _____
3. Were you provided with a private bathroom? _____
4. To what residence hall were you assigned sophomore year? _____
5. Was your room assignment sophomore year single or double occupancy? _____
6. Were you provided with a private bathroom? _____



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- 7. To what residence hall were you assigned junior year? _____
- 8. Was your room assignment junior year single or double occupancy? _____
- 9. Were you provided with a private bathroom? _____
- 10. To what residence hall were you assigned senior year? _____
- 11. Was your room assignment senior year single or double occupancy? _____
- 12. Were you provided with a private bathroom? _____

D. Relevant diagnosis(es) (disability or chronic medical condition): _____

E. List the housing accommodation(s) you are requesting: _____

F. How do you anticipate managing your symptoms in other campus settings (e.g. classrooms, dining halls, etc.)? _____

G. Explain how the accommodations you are requesting will impact your current symptoms. _____

Please list below the health care professional(s) you are authorizing to provide information for consideration by Housing Accommodation Committee:

Name/Phone Number of Provider(s): _____

By my signature, I give my consent for Student Accessibility Services to contact my treating professional for additional information

Student's Signature: _____ **Date:** _____



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PART II: TO BE COMPLETED BY CERTIFIED TREATMENT PROFESSIONAL

(Part II should only be completed if this is a new request NOT a renewal.)

Name of Student: _____ **Date of Birth:** _____

A. DSM IV/ICD 9 Diagnosis: _____
 Diagnosis Date: _____
 Date of Last Evaluation or Clinical Contact: _____
 Test/Assessments Used to Diagnosis Condition(s): _____

The Condition Is: _____ permanent ___ temporary (anticipated duration: _____)

B. In your opinion, does any impairment listed above **substantially limit a major life activity in the college residential environment?** _____ Yes _____ No

If yes, specify here: _____

C. Please list any current prescribed medication(s), dosage, frequency, and possible side effects of the medication(s) **as it relates to the need for university residential accommodations.**

D. How will the student manage these symptoms in other campus settings (e.g., classrooms, etc.)

E. List any *recommendations for accommodations* appropriate for this student in a residential setting. The accommodations must link to the functional limitation. _____



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F. Could this student be at risk during emergency evacuation? Yes No

If yes, please explain: _____

In an effort to best meet the individual needs of the student as it related to disability-related housing accommodations, it is often necessary for Student Accessibility Services to gather additional information from treatment professionals. In this section, we provide you with areas to consider when thinking about the types of accommodations that may be most helpful to the students.

G. Please indicate if there are any other relevant concerns regarding the provision of disability-related housing accommodations:

Check all that apply and explain in the space provided:

- Environmental condition that may exacerbate the disability or disabilities
- Personal care needs
- Residence hall location/room
- Space and storage needs (e.g., medication storage)
- Bathroom considerations
- Consideration of chemical sensitivities
- Food allergies
- Emergency evacuation needs
- Other _____

H. To your knowledge, will the student have a Personal Care Assistant (PCA)? Yes No

If yes, please indicate the frequency of care that the student will likely need. This information will be used to aid Residence Life in assessing the type of access the student's PCA will need in order to assist the student if they reside in a residence hall.

Frequency: _____



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Treatment/Assessment Professional Information

Printed Name and Title: _____

Licensing credential, number and state: _____

Provider signature: _____ Date: _____

Agency/Practice: _____

Street: _____ City: _____

State: _____ Zip: _____ Phone: () _____

My signature verifies that I am a treatment/assessment professional and that the contents are accurate.

Please submit completed forms to:

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