SUNY Cortland

Disability Resources Office

Medical/Disability Housing Accommodations Request Form

To provide Housing Accommodations for Medical Reasons, SUNY Cortland requires students to submit this detailed assessment by a qualified health professional describing their disability to the professional representative in the Disability Resources Office.

If you have a substantial basis that supports your medical/disability housing accommodation request, the Director of Disability Resources will need the following four (4) steps completed in order to make a final determination.

PLEASE BE AWARE THAT ALL STEPS MUST BE COMPLETED BEFORE A DETERMINATION CAN BE MADE

1. Please fill out the student portion of the Housing Request Form (see below) with your name and the type of room accommodation you are requesting. Have the rest of the form completed by your health care provider indicating medical necessity and recommendation for your request.

2. Fill out the "***Authorization for Release of Confidential Information***" form in case the Director needs to talk with provider.

3. Complete the ***"New Student Accessibility Request"*** online form at:
   https://cortland-accommodate.symplicity.com/public_accommodation/

4. You must speak with the Director of Disability Resources, Sue Sprague, to review the information that has been submitted. Please make an appointment for an in-person meeting during the academic year or a phone conversation by calling the office at (607) 753-2967 or e-mailing disability.resources@cortland.edu.

TO BE FILLED OUT BY STUDENT

Student's Name: _____

Please check one room type: ☐ Single ☐ Double ☐ Suite ☐ Quad ☐ West Campus Apartment (2 Miles from Center of Campus)

Please Check Requested Accommodations Below

- ☐ Wheelchair accessible toilet, sink and shower facilities
- ☐ Wheelchair accessible bedroom
- ☐ Building with automatic opening power doors
- ☐ Release from residence hall contract (room and board)
- ☐ Hall with elevators
- ☐ Assistance/Emotional Support Animal (separate documentation packet needs to be completed)
- ☐ Visual alerting devices
- ☐ Housing with accessible parking
- ☐ Hall with air conditioning
- ☐ Bed Shaker
- ☐ Other: _____

Please have your provider complete this form and send to:

Sue Sprague, Director
Disability Resources Office
SUNY Cortland
PO Box 2000
Cortland, NY 13045
Office: (607) 753-2967; Fax: (607) 753-5495; E-Mail: disability.resources@cortland.edu

HEALTHCARE PROVIDER'S ASSESSMENT (To be filled out by PROVIDER)

Health professional's name: (please print) _____ Date: _____ Clinic name and address: _____ _____ Clinic Phone: _____	*Place Stamp Here*

1. What is the diagnosis? (Include DSM-V diagnosis code or method/evaluation (lab work, etc.) used to determine diagnosis)

2. Date diagnosis was made?

3. Summary of symptoms for which the treatment started:

4. What treatment has been implemented?

5. Is the patient/student currently under your care?

   ☐ Yes

   ☐ No

6. What date did you last see the patient/student?

7. What are the Functional Limitations resulting from the diagnosis that impact on major life activities, which include but are not limited to: caring for oneself, performing manual tasks, seeing, hearing, eating, sleeping, walking, standing, lifting, bending, speaking, breathing, learning, reading, concentrating, thinking, communicating, and working as related to the patient/student living in on-campus housing?

8. Based upon the major life activities affected by the diagnosis, are there any accommodations within the context of college housing that you can recommend?

9. Are recommended housing accommodations medically necessary for this student at college?

Signature and Title of Licensed Healthcare Provider _____ Date _____

******Note to Provider* **- The student has been asked to sign a release to allow communication between us should clarification be needed.**

SUNY Cortland

Disability Resources Office

Authorization for Release of Confidential Information

I, _____ , authorize and request _____ to release/discuss with the SUNY Cortland Disability Resources Office, the following information:

- ☐ Medical information concerning the history, treatment, examinations, laboratory studies and/or hospitalizations pertaining to the student's disability
- ☐ Psychological/psychiatric assessment and treatment describing disability
- ☐ Other _____

I understand I may revoke this consent at any time except to the extent that the action has already been taken on it and that it will expire automatically one (1) year from the date indicated below.

NOTE: Federal rules prohibit you from making any further disclosure of this information "unless further disclosure is expressly permitted by the written consent of the person to who it pertains or is otherwise permitted by 42 CFR, part 2."

Signature: _____ Date of Birth: _____

Date: _____

Witness Signature: _____