

# REQUEST FORM FOR DISABILITY HOUSING ACCOMMODATIONS THE SAGE COLLEGES

Please refer to the *Disability Housing Accommodations Policy* for the complete process for requesting disability-related housing accommodations, including deadlines. Students must follow these procedures and provide all of the required information in order to be considered for disability housing accommodations.

## **PART I**

*(to be completed by the student)*

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Permanent Address: \_\_\_\_\_

Anticipated Move-In Date: \_\_\_\_\_

OR

Already Living in Sage Housing (specify location): \_\_\_\_\_

E-mail Address: \_\_\_\_\_ Preferred Phone: \_\_\_\_\_

Current Academic Status:

\_\_\_ Freshman

\_\_\_ Junior

\_\_\_ Sophomore

\_\_\_ Senior

\_\_\_ Other: \_\_\_\_\_

Please specify your disability: \_\_\_\_\_

If this request is due to a temporary condition, please indicate expected duration: \_\_\_\_\_

Disability Accommodations Requesting:

\_\_\_ Single Room

\_\_\_ Private Bathroom

\_\_\_ Wheelchair Accessible Unit

\_\_\_ Accessible building

\_\_\_ Flashing Alarm

\_\_\_ Air conditioned building

\_\_\_ Comfort Animal

\_\_\_ Other: \_\_\_\_\_

\_\_\_ I DO require emergency evacuation assistance.

Describe: \_\_\_\_\_

\_\_\_ I do NOT require assistance with emergency evacuation.

**PLEASE NOTE:** Disability documentation is required to consider a request to have a comfort animal in Sage housing as a reasonable accommodation for a disability. Such documentation is **NOT** required for a service animal. See The Sage Colleges policy on Service and Comfort Animals.

You may also attach a personal statement describing your condition and your need for each of the accommodations that you are requesting.

Please have a qualified medical or other licensed health care provider complete PART II of this application.

Signature: \_\_\_\_\_

**REQUEST FORM FOR DISABILITY HOUSING ACCOMMODATIONS  
THE SAGE COLLEGES**

**PART II**

**CERTIFICATION OF DISABILITY**

**To the Student: THIS FORM MUST BE FILLED OUT IN ITS ENTIRETY BY YOUR TREATING HEALTH CARE PROVIDER.** If this form is completed by anyone other than a qualified licensed health care professional, the information provided may not be used to support your accommodation request and The Sage Colleges reserves the right to request additional documentation. Since a request for additional information can result in a delay in your request for accommodations, you are strongly urged to have the form completed by a qualified licensed health care professional who will include all requested information.

**To the Evaluator:** The student named below has represented that s/he has a disability which will require a housing accommodation at The Sage Colleges. The information you provide will be used to determine the appropriateness of the requested accommodation(s). **Please take the time to complete this form and thoroughly answer all questions.** We must receive an original form with your signature. We cannot accept substitutions for this form but you may provide supplemental information on official letterhead. Please contact us with any questions. All information provided to us is confidential. With the student's permission, we may contact you directly for additional information to assist us in making a determination.

**Student Name:** \_\_\_\_\_

**Health Care Provider:**

**Please respond to the following questions regarding the above named student.**

1. Please identify the physical or mental impairment for which you are treating the student:

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2. Please list date of onset and severity: \_\_\_\_\_

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3. How long have you been treating the student? \_\_\_\_\_

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4. When was the last date of treatment you had with the student? \_\_\_\_\_

5. Please list any current functional limitations and impact on activities of daily living in residence halls:

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6. For each and every accommodation requested in PART I, please describe why the requested accommodation is necessary:

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7. How, if at all, does each requested accommodation impact the current treatment plan for the student?

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8. If single housing or private bathroom is requested, please identify alternative accommodations that would address the student's needs in the event that the requested accommodation cannot be provided.

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Healthcare Professional Name: \_\_\_\_\_

Professional Licensure: \_\_\_\_\_ State: \_\_\_\_\_ Number: \_\_\_\_\_

Healthcare Professional Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Office Address: \_\_\_\_\_ Phone: \_\_\_\_\_