Housing Accommodation Request Form for Students with Disabilities

Students with disabilities that require a specific type of housing assignment to ensure equal access to the housing program may request a housing accommodation through Disability Support Services (DSS). Housing accommodation requests are reviewed by committee. For qualified students with documented disabilities whose requests are approved by the committee, DSS recommends housing accommodations to the Office of Housing and Residence Life. Housing placements are prioritized based on documented need. When possible, the preferences of the students are considered. Please note that late requests will be accepted. However, it is not guaranteed that late requests – even if approved – will be able to be accommodated based upon availability.

Directions to Students:
- Complete Part I
- Sign the Consent for Release of Information in Part I and Part II
- Provide Part II to your disability evaluator or physician
- *Both parts must be returned to DSS by March 5, 2021 for current students, and May 1, 2021 for new incoming students.*
- Please note: housing deposits and housing applications through the Department of Housing and Residence Life and must be received by the deadline in order for accommodation requests to be considered.

Part I: Student to complete the following:

Name (please print clearly): ________________________________

SHU ID#: ________________________________

Student Cellular #: ________________________________

SHU Email: ________________________________

Status/Campus: □ Incoming Freshman □ Transfer □ Returning

Accommodation Request is for: □ Fall □ Spring □ Summer Year: ________________________________

1. State the disability for which you are requesting a housing accommodation:

____________________________________________________________________________________

____________________________________________________________________________________

2. Please explain the housing accommodation(s) you are requesting.

____________________________________________________________________________________

____________________________________________________________________________________
3. Have you had this accommodation at Seton Hall University in the past? ____________________

4. Please describe how this accommodation will reduce the impact of your disability in the residence halls.

_________________________________________________________________________________

_________________________________________________________________________________

_________________________________________________________________________________

5. Do you require the use of an elevator? _______ Yes _______ No

6. Can you go up/down stairs? _______ Yes _______ No

7. Will you require assistance in an emergency evacuation? _____ Yes _______ No

8. Will you require audio or visual alarms for emergency egress in your individual room? (Please note that audio/visual alarms are standard in the common areas of the residence halls.) __________ Yes __________ No

9. Please add any other information you feel is important for us to consider in reviewing your request.

_________________________________________________________________________________

_________________________________________________________________________________

_________________________________________________________________________________

10. Would you like Disability Support Services to contact you regarding disability related academic accommodations or support services? Yes________ No_______

Student Signature: ____________________________ Date: ____________________

Consent for Release of Information (to be completed by student):

I authorize_________________________(physician or evaluator’s name) to disclose the information requested by this form to the office of Disability Support Services at Seton Hall University for the purpose of evaluating my request for housing accommodations. I also allow both parties to discuss any information related to my housing accommodation request. I understand that my personal medical information will be shared on a “need to know basis” with other university offices.

Student Signature:_____________________________ Date:__________
Part II: Physician or Disability Evaluator Verification

Accommodations are only available to students identified as having a disability. A disability is defined under the Americans with Disabilities Act as “a physical or mental impairment that substantially limits one or more major life activities.” Examples of major life activities are: Major bodily functions, seeing, hearing, eating, sleeping, walking, standing, lifting, bending, speaking, breathing, learning, reading, concentrating, thinking, communicating, working, performing manual tasks, and caring for oneself.

1. Based on this definition does the individual have a disability? ______ Yes ______ No
   Date of original diagnosis: ________________ Date of most recent evaluation: ________________
   Is the student currently under your care? _________ Yes ______ No

2. State the student’s disability diagnosis, including diagnostic code.

3. Describe the student’s functional limitations or behavioral manifestations caused by the condition. Please describe the type, severity, and frequency of symptoms related to this disability? What do you foresee as the impact living in a college residential hall setting?

4. What is the expected duration, stability, or progression of the disability?
5. Please describe current treatments, prosthetic devices, and or medications prescribed.

__________________________________________________________________________________________________________________________________________

6. Is the disability mediated or controlled by medications, other treatments, or external prosthetics?  ___ Yes  ___ No
   Please explain:  __________________________________________________________________________

7. Is this request medically necessary, or recommended to enhance the comfort and convenience of the student? If medically necessary, please explain how the accommodation relates to the impact of the condition.

__________________________________________________________________________________________________________________________________________

__________________________________________________________________________________________________________________________________________

__________________________________________________________________________________________________________________________________________

8. Is the impact of the condition life threatening if the request is not met?  ___ Yes  ___ No

9. Is there a negative health impact that may be permanent if the request is not met?  _____ Yes  ________ No

10. Is the request an integral component of a treatment plan for the condition in question?  ____ Yes  ____ No

11. What is the likely impact on academic performance if the request is not met?  ___________________________
   _______________________________________________________________________________________
   _______________________________________________________________________________________

12. What is the likely impact on social development if the request is not met?  ___________________________
   _______________________________________________________________________________________
   _______________________________________________________________________________________

13. What is the likely impact on the student’s level of comfort if the request is not met?  __________________
    _______________________________________________________________________________________
    _______________________________________________________________________________________

14.  ___________________________
    _______________________________________________________________________________________
Physician or disability evaluator INFORMATION (Please Print)

Name: ______________________________________________________
Title: _____________________________ Specialty: _____________________________
Office Address: ______________________________________________________
Phone: _____________________________
License/Certification Number and State of License _____________________________
How long have you treated this patient? _____________________________
Date of most recent office visit? _____________________________
May we contact you if we have questions about this student’s accommodation request? ____Yes ______ No

Signature: _____________________________ Date: ______________

PLEASE MAIL, FAX or EMAIL COMPLETED FORM TO:
Disability Support Services
Seton Hall University
400 South Orange Avenue, South Orange, NJ 07079
(973) 313-6003 (p), (973) 761-9185 (f)
dss@shu.edu