The College of Saint Rose  
Housing Accommodation Request

Instructions and Information

Students who are requesting a housing accommodation based on a disability or chronic medical condition should follow the steps outlined below. While the College of Saint Rose seeks to support students in a holistic manner, our ultimate goal is to provide all students with an equal opportunity to benefit from the programs and activities of the College. Some requests may be deemed unreasonable and/or may present an unreasonable administrative or financial burden to the institution. In these cases College staff will work with students to help identify alternative arrangements. Please direct any questions or need for clarification to the address below.

The attached Housing Accommodation Request Form must be completed in full. As indicated on the form, appropriate sections must be completed by a qualified and licensed health or mental health professional. If a care provider prefers to submit a letter on a student’s behalf, it must be submitted on letterhead and all questions on the form must be fully addressed.

Please keep in mind that completion of this form does not guarantee that an accommodation request will be approved. All documentation will be maintained as confidential in accordance with state and federal law and should be submitted to:

The Office of Services for Students with Disabilities  
The College of Saint Rose  
432 Western Ave.  
Albany, NY 12203  
Phone: (518) 337-2335  
cantwell@strose.edu

Upon receipt of an application, the Office of Services for Students with Disabilities will perform an initial review to determine that the Housing Accommodation Request Form has been completed in full and that the impact of a student’s condition is significant enough to consider reasonable accommodation under the Americans with Disabilities Act as amended and Section 504 of the Rehabilitation Act. Provided that the above conditions are met, the application will be forwarded to the Housing Accommodation Committee for review and, if appropriate, identification of specific accommodation. The Committee reserves the right to request additional information from the student as necessary. In the event that the Committee requires more information to make a decision, the student will be asked to sign a release allowing a Committee member to contact the professional who completed the form. Inquiries to health care providers will be limited to the need to address the student’s specific housing accommodation request including but not limited to determining disability status, rationale for the request and discussion of other potential alternative accommodations.

A decision regarding specific requests will be communicated to students by a member of the Housing Accommodation Committee, which will make a good faith effort to notify the student of the status of his/her request in a timely manner. Any housing accommodation request which is granted, that does not constitute a personal need, will be at no additional cost to the student. The College reserves the right to pair students with similar environmental, physical, and/or scheduling accommodations in lieu of offering a single room.

**Appeal Process**

A student who wishes to appeal a decision made by the Housing Accommodation Committee may do so by submitting written notification to the Assistant Vice President for Student Development at the address above. A letter of appeal should be submitted within 5 days of the decision notice.
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Housing Accommodation Request Form

Name: ________________________________________   Date: ______________ I.D. #:_________________________

Residence Hall: ___________________________   Cell Phone #: _____________________________________

Home Address: ____________________________________________________________________________________

E-mail address: _________________________________________________ Gender: ____________________________

Student Status:   ____Freshman     ____Transfer      ____Sophomore      ____Junior _____Senior

Please explain request:

I am requesting this accommodation as of (date or semester): _______________________________________________

Student’s Signature: ________________________________________________________________________________

Please have your physician/health care provider/therapist complete the following section of this form. Please print clearly and legibly.

This request is the result of a permanent and/or recurring condition and I will need to be accommodated for the remainder of the time I reside in campus housing. _____ Yes       _____ No

Student is a: ____ Non-Smoker ____ Non-Smoker who will live with a smoker   _____ Smoker

Physician/Health care Provider/Therapist’s Name: _______________________________________________________

Address: _________________________________________________________________________________________

Phone Number: _________________________   Physician/Therapist’s Signature: _____________________________

Clinical diagnosis: _____________________________________________Date of initial Diagnosis: _________________

How long has the student been in your care? ______________ When was the student’s last visit? ________________

Please explain the impact of the student’s condition(s) on his/her daily life:
Please identify what housing accommodations you believe are necessary to accommodate the student’s condition(s) and the basis of your recommendations:

If the student has previously resided on campus without your recommended accommodation, please explain why your recommendations are now necessary:

Please explain how the student will be impacted if the requested accommodation is denied:

Please describe any environmental modifications the student may need:

- [ ] lowered bed
- [ ] shower seat/ safety rails
- [ ] special fire alarm (strobe, bed shaker, etc.)
- [ ] ground floor or elevator
- [ ] separate refrigerator for medication
- [ ] other (explain) _____________________________________________________________________

**Staff Use only:**

Approved: _____  Denied _____  Date: ________________________