Student Name: _____

Bronco ID: _____ Date: _____

Applicant Status (Mark "X"): **Current/Returning Applicant** _____ or **New Applicant** _____

FAYETTEVILLE STATE UNIVERSITY

COUNSELING AND PERSONAL DEVELOPMENT CENTER

Housing Accommodation Request Form

Fayetteville State University Student Disability Services (SDS) works in conjunction with the Department of Housing and Residence Life (HRL) to provide accessible on-campus housing that meets students with approved disability-related needs.

Disclaimer: Having a diagnosis alone does not automatically qualify a student for accommodations. This is not a preference-based application or process based upon personal desires. The eligibility review process focuses on whether the condition results in substantial functional limitations in one or more major life activities (such as walking, breathing, eating, sleeping, caring for oneself, or other daily living activities). These limitations are considered in terms of their severity, frequency, and duration.

Submission Deadlines: To ensure your housing accommodation request is considered, you must meet the following appropriate deadline and satisfy all SDS Housing process requirements:

- **Current/Returning Applicants: Submit a completed application by March 15, 2025**
- **New Applicants: Submit a completed application by May 15, 2026**
- In addition to submitting your application by the deadline, **you must**:
  - Complete FSU's primary housing process as outlined by the Department of Housing & Residence Life.
    - A submitted application does not guarantee approved SDS housing accommodations.
  - Be aware that this process is capacity-based and subject to availability.

Part 1: Student Section (to be completed by student)

Student Date of Birth: _____ Email: _____@broncos.uncfsu.edu

Student Primary #: _____ (cell/hm) Secondary #: _____ (cell/hm)

Address: _____

Current Academic Level: □ **Freshman** □ **Sophomore** □ **Junior** □ **Senior** □ **Graduate**

Semester(s) Requesting Accommodation: □ **Fall 2026** □ **Spring 2027** □ **Summer 2027**

Student Name: _____
Bronco ID: _____

Do you have any Medical, Psychological, Physical or Disability Related Conditions that would affect your housing assignment? □ Yes □ No (If yes, circle all that apply)

Please describe the condition(s) for which you are requesting a housing accommodation and explain how they impact your living environment thoroughly with use of detail:

1. **Diagnosis or Condition:** Please list the *licensed clinician-verified* diagnosis/diagnoses relevant to your housing accommodation request; self-diagnosis conditions are not accepted.

_____
_____

2. **Impact on Housing:** Describe, in detail, how this condition affects major life activities related to your housing or living environment; reference *major life activities* listed on page #1.

_____
_____
_____
_____
_____
_____

3. **Severity:** How significantly does this impact your daily functioning in housing? Include symptom details related to previously listed certified diagnosis/diagnoses/condition.

_____
_____
_____
_____
_____
_____

4. **Frequency:** How often (daily/wkly/mthly/random/etc.) do these limitations occur? Please explain.

_____
_____
_____

5. **Duration:** Describe how long these limitations have been present & are they expected to continue?

_____
_____
_____

Student Name: _____
Bronco ID: _____

Please check the accommodation being requested for the term indicated.

☐ **Single Room** (approval based on major functional limitations and room availability)	☐ **Wheelchair accessible dorm**
☐ **Private/Semi-Private Bathroom** (not viewed automatically w/sing room; medical/disability need present; not personal preference based)	☐ **Wheelchair accessible furnishings**
☐ **ADA Compliant Bathroom** (including roll-in shower)	☐ **Room with additional space for medical equipment**
☐ **First floor room access**	☐ **Visual doorbell** (typically for students with hearing impairments)
☐ **Other:** _____	☐ **Other:** _____

If the requested accommodation is unavailable or documentation does not sufficiently support eligibility criteria, please describe any housing-related strategies, interventions, accommodations or coping mechanisms that have been effective for you in the past. _____

_____

_____

Alternative Measures Taken Prior to or Alongside Housing Request: Please indicate whether each applies to you in the past, currently, or both.

Support or Strategy	Past	Current	Both
Medication management	O	O	O
Individual therapy or counseling	O	O	O
Group therapy or support groups	O	O	O
Coping strategies or self-management techniques	O	O	O
Environmental or routine modifications (e.g., earplugs, air purifiers, schedule adjustments)	O	O	O
Temporary or informal housing adjustments	O	O	O
None of the above	O	O	O
Other (please describe): _____	O	O	O

Student Name: _____
Bronco ID: _____

If you are specifically requesting a single room accommodation and request is unable to be honored, are you willing to be placed with student needing similar accommodation? □ Yes □ No

Is accommodation for a temporary or permanent condition: If temporary, provide expected duration.

_____

_____

Disclaimer: All requests will be prioritized in the order they are received. Applications received after the stated deadline will be reviewed based on an availability basis. All housing requests are evaluated on a case-by-case basis. Students will be notified by way of Bronco email account.

The date you submit your application request marks the start of the review timeline. A full documentation review **may take up to 10 business days (excluding weekends/holidays)** for the FSU SDS Review Team to review your submission, validate signatures, verify information, confirm completeness, assess functional impact, severity of need, eligibility assessments, etc. Insufficient or incomplete documentation may cause delays, which is why the Preparation Stage is so important.

- Based on your Applicant status, have you met the SDS Housing Deadline for the current term requesting? □ Yes □ No
  - **Current/Returning Applicants:** Student with current housing accommodation
    - **Deadline:** March 15, 2025
  - **New Applicants:** Student without or never obtained SDS housing accommodation
    - **Deadline:** May 15, 2026

Student Certification:

□ **By checking this box and signing, I attest that the information and documentation I have submitted are true, accurate, and have not been altered, falsified, or misrepresented. I understand that it is my responsibility to meet all deadlines and submit sufficient documentation for review.**

Student Name (Print) _____ Date: _____

Student Name (Signature) _____

Student Name: _____
Bronco ID: _____

Student Consent for Release of Information

Disability Services staff may contact my treating provider to verify the information submitted for my request, and an exchange of information may need to take place. I give my permission for such communication as necessary with my treating provider named below.

Student Consent:

I, _____, authorize my health-care provider above to release to Student Disability Services the medical information requested on this form for the purpose of determining appropriate accommodation for my disability while a student at Fayetteville State University.

Student Name (Print) _____ Date: _____

Student Name (Signature) _____

If signed by person other than patient, state relationship and authority to do so:

_____ Expiration Date: _____

Student Name: _____
Bronco ID: _____

Part 2: Certified Provider (to be completed by Provider)

Physician/Medical Provider Printed Name: _____

Provider Signature: _____ **Provider Initials** _____

Medical Specialty: _____

License # & State: _____

Name of Practice: _____

Phone #: _____ **Email:** _____

Address: _____

City, State, Zip: _____

Website (if applicable): _____

Initial Date of Treatment with Student: _____ **Total # of visits w/student:** _____

Diagnosis/Diagnoses of Medical Condition(s), Psychological Disorder or Primary Disability

List Diagnosis/Diagnoses: _____

_____

_____

Original date of diagnosis/diagnoses: _____

Dates of last two treatments with student as signing Provider: _____

_____

List medication used for treatment for condition(s): _____

_____

_____

Prognosis for Diagnosis/Diagnoses:

□ Permanent/Chronic □ 6-12 Months □ 6 Months or Less □ Episodic

Please check: □ **Temporary** □ **Permanent condition:** If temporary, provide expected duration.

_____

Severity of the condition: □ Mild □ Moderate □ Severe

Student Name: _____
Bronco ID: _____

Provider Attestation of Clinical Evaluation and Documentation

Thank you for your collaboration and professional support. Please initial each statement below to indicate your agreement and understanding:

Provider Initials: _____
I attest that the information and documentation I am providing are accurate, complete, and based on my clinical judgment.

Provider Initials: _____
I confirm that my assessment reflects a documented need for housing accommodations due to substantial functional limitations related to the student's **current** condition and its impact on functioning; current symptoms and functional limitations are required to support reasonable accommodation decisions.

Provider Initials: _____
I understand that the need for accommodations is based on documented severity, frequency, and duration of symptoms and functional limitations, **not** personal preference or convenience.

Provider Initials: _____
I confirm that I have a **previous and ongoing** clinical relationship with the student and am not completing this form solely to fulfill documentation requirements; one-time or brief visits rarely generate sufficient clinical data for housing accommodation recommendations.

Provider Initials: _____
I understand that SDS housing spaces are limited and that requests are reviewed case by case to ensure appropriate support for students with the most significant documented need.

Provider Initials: _____
I acknowledge that a diagnosis alone does not automatically qualify student for housing accommodations; qualification is based on functional impact specifically related to housing needs.

Provider Initials: _____
I understand that falsifying or misrepresenting clinical information may violate ethical or professional standards and may affect the documentation's validity.

Student Name: _____
Bronco ID: _____

Please describe the condition(s) for which you are requesting a housing accommodation and explain how they impact your living environment thoroughly with use of detail:

1. **Diagnosis or Condition:** Please list students' diagnosis/diagnoses relevant to housing accommodation request.

   _____
   _____

2. **Impact on Housing:** Describe, in detail, condition affects major life activities related to students housing or living environment; reference *major life activities* listed on page #1 or #10.

   _____
   _____
   _____
   _____
   _____
   _____

3. **Severity:** How significantly does this impact students' daily functioning in housing? Include symptom details related to previously listed certified diagnosis/diagnoses/condition.

   _____
   _____
   _____
   _____
   _____
   _____

4. **Frequency:** How often (daily/wkly/mthly/random/etc.) do these limitations occur? Please explain.

   _____
   _____
   _____

5. **Duration:** Describe how long these limitations have been present & are they expected to continue?

   _____
   _____
   _____

Student Name: _____
Bronco ID: _____

Based on the previous section, identify recommended accommodations.

☐ **Single Room** (approval based on major functional limitations and room availability)	☐ **Wheelchair accessible dorm**
☐ **Private/Semi-Private Bathroom** (not viewed automatically w/single room; medical/disability need present; not personal preference based)	☐ **Wheelchair accessible furnishings**
☐ **ADA Compliant Bathroom** (including roll-in shower)	☐ **Room with additional space for medical equipment**
☐ **First floor room access**	☐ **Visual doorbell** (typically for students with hearing impairments)
☐ **Other:** _____	**Other:** _____

Justification for Housing Accommodation Requests

Please provide a specific explanation for **each** recommended SDS housing accommodation. Clearly describe how the requested accommodation is medically necessary and how it enables the student to have equal access to campus housing.

Justification Disclaimer: For single room request, explain how sharing a room would **adversely affect the student's ability to live in the residence hall**. Please note that a private bathroom request is **not** an automatic request which mirrors a single room request. Private bathroom request must also be explained in detail and is **evaluated independently.** Examples of when a private bathroom may be necessary is when documented disability-related limitations cannot be reasonably managed in shared facilities, such as frequent or unpredictable elimination needs, heightened risk of infection exposure, or the need for specific physical space or safety features that shared restrooms cannot provide. Any explanation must clearly link the accommodation to the student's documented functional limitations and disability-related needs.

In the space below, please provide justification for **each** SDS housing accommodations you've recommended: _____

_____
_____
_____
_____

In the event more space is needed, additional supporting documentation is accepted. Please attach.

Student Name: _____
Bronco ID: _____

In the space provided, please address the following: If accommodation is not provided, will there be a negative health impact for the student? What other alternative accommodations could satisfy reasonable accommodations? _____
_____
_____
_____
_____

Please check which of the following major life activities is substantially limited by the disability as it relates to on campus living/housing:

□ Seeing	□ Speaking	□ Immune System Function
□ Hearing	□ Breathing	□ Digestive Function
□ Eating	□ Thinking	□ Bowel/Bladder Function
□ Sleeping	□ Concentrating	□ Neurological Function
□ Walking	□ Communicating	□ Respiratory Function
□ Standing	□ Working	□ Circulatory Function
□ Lifting	□ Caring for Oneself	□ Endocrine Function
□ Bending	□ Performing Manual Tasks	
□ Other(s): _____		

By signing below, I agree that the information provided above is accurate to the best of my knowledge. I understand that these are accommodation recommendations, and that they do not guarantee the student above recommendations, and that accommodations will be determined by the University's office of Disability Services.

Provider Name (Print) _____ **Date:** _____

Provider Name (Signature) _____

Counseling and Personal Development Center

Student Disability Services

Phone: (910)-672-1222 **Email:** Disabilityservices@uncfsu.edu

FSU SDS Webpage: Visit **uncfsu.edu** → use the site search to look for **"Student Disability Services"** under "Counseling and Personal Development Center."