



ACCESSIBILITY
RESOURCE
CENTER

ACCESSIBILITY RESOURCE CENTER
500 Grand Concourse Bronx, NY 10451, D101-L
Telephone/Fax: (718) 518-4454/4433

ACCOMMODATIONS QUESTIONNAIRE

Date: _____

STUDENT INFORMATION

Name: _____ EMPL ID#: _____

Address: _____ Apt. # _____

City: _____ State: _____ ZIP Code: _____

Home Phone: (____) _____ Cell Phone : (____) _____

E-mail Address: _____

Date of birth: _____ Gender: Male Female X

Place of birth: _____

Are you Latino/a? Y N ; Race/Ethnicity: _____

Marital Status: Single Married Partner

Do you have children? Y N

Are you eligible to work in US? Y N

Do you have veteran status? Y N

Select voter registration status:

Registered Ineligible to vote Registration mailed Declined registration

Who referred you to this office/how did you learn about the office?

What is your disability or medical condition?

If you have no known disability, what is the reason you came to the office?

EDUCATION INFORMATION

High School _____ City _____ State ____ Country _____

Date HS Diploma received _____ OR Date GED received _____ ENG. SPA.

If you received a GED what is the highest grade you completed? _____

Did you have an Individual Education Plan (IEP) in High School? Y N

Have you previously enrolled in college? Y N

If yes, name of college: _____

State: _____ Years attended: _____

Please list services/accommodations you received at any previously attended school:

Are you affiliated with the following?

ASAP CD CUNY Start Coaching Unit WIPA EDGE CLIP

Class Status: First Year Freshman First Year Transfer Readmit

Date of the admission to Hostos: _____ Major: _____

Number of college credits completed: _____ Current GPA: _____

CUNY LEADS

Linking Employment, Academics and Disability Services (LEADS) helps students successfully connect their academics to their career goals.

Are you currently employed? Y N ; If yes, please complete the following:

Full-time Part-time Temporary Internship

Employer name: _____

Job title: _____

Start Date: _____ Hourly rate: _____

If no, have you worked previously? Y N ; If yes, how long and what kind of work?

Career or Employment Goals:

SPONSORING AGENCIES

Select agency if you receive support from any of their services from the following list:

SSI

SSDI

Adult Career and Continuing Education Services- Vocational Rehabilitation (Acces-VR)

Commission for the Blind and Visually Handicapped (CBVH)

VA Rehabilitation Services

Other, please specify: _____

DISABILITY RELATED INFORMATION

Please answer the following questions regarding your disability and how it impacts your ability to learn, attend, and participate in college life.

Please indicate your disability type(s). Check all that apply:

- | | |
|---|--|
| <input type="checkbox"/> Learning Disability | <input type="checkbox"/> Chronic Medical Condition, please specify:
_____ |
| <input type="checkbox"/> Attention Deficit/Hyperactivity Disorder (AD/HD) | <input type="checkbox"/> Psychiatric Disability, please specify:
_____ |
| <input type="checkbox"/> Visual Impairment or Blindness | <input type="checkbox"/> Other, please specify:
_____ |
| <input type="checkbox"/> Deaf or Hard of Hearing | |
| <input type="checkbox"/> Physical Disability, please specify:
_____ | |

Please check all that apply

- | | |
|---|---|
| <input type="checkbox"/> I use a wheelchair. | <input type="checkbox"/> I have difficulty standing for long periods of time. |
| <input type="checkbox"/> I wear a hearing aid. | <input type="checkbox"/> I tire easily when I walk distances. |
| <input type="checkbox"/> I have a cochlear implant. | <input type="checkbox"/> I have difficulty walking up/down stairs. |
| <input type="checkbox"/> I need to read lips of instructors. | <input type="checkbox"/> I use a brace, crutches, cane, or prosthesis. |
| <input type="checkbox"/> I rely on sign-language interpreting services. | <input type="checkbox"/> I utilize assistive technology. |
| <input type="checkbox"/> I have difficulty reading the blackboard. | <input type="checkbox"/> Other, please specify:
_____ |
| <input type="checkbox"/> I have difficulty taking notes in class. | |
| <input type="checkbox"/> I have difficulty writing. | |

Are you currently taking any medication related to your disability or medical condition? If so, please list all of the medications you are taking.

Please also list any side-effects of the medications that you are taking and their impact on your academic/cognitive abilities and/or other activities.

I am requesting the following accommodations:
