

The City College  
of New York

**Division of Student Affairs**

Willie Administration Building, The City College of New York  
160 Convent Avenue New York, NY 10031 (212) 650-5426

AccessAbility Center/Student Disability Services  
North Academic Center, Room 1/218  
Convent Avenue at 138th Street  
New York, New York 10031  
Voice: 212-650-5913 Fax: 212-650-5772  
TTY/TTD: 212-650-8441  
[disabilityservices@ccny.cuny.edu](mailto:disabilityservices@ccny.cuny.edu)

**APPLICATION FOR ACCOMMODATIONS AND SERVICES**

*This application is for students who are interested in registering with The AccessAbility Center/Student Disability Services (AAC/SDS) and requesting academic adjustments, auxiliary aids, and services covered under the Americans with Disabilities Act of 1990, Amended in 2008, Section 504 of the Rehabilitation Act of 1973, and the Fair Housing Act of 1968. Please ensure that you complete the form, date and sign it, and provide supporting documentation. If your provider completes the Request for Disability Documentation Provider Form, that will serve as supporting documentation. Allow for at least one week for the AAC/SDS to review this application and supporting documentation. Please ensure to drop off your supporting documentation before your intake. You will be scheduled for a formal intake upon review.*

**General Information**

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

Address \_\_\_\_\_ City \_\_\_\_\_

State \_\_\_\_\_ Zip \_\_\_\_\_ Email Address \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell/Work/Other \_\_\_\_\_

Birth Date \_\_\_\_\_ EMPL ID \_\_\_\_\_

How did you hear about this office/who referred you to this office? \_\_\_\_\_

**Disability Information**

**Please indicate your disability type(s). Please check the boxes that apply:**

- |   |   |
|---|---|
| <input type="checkbox"/> ADHD                           | <input type="checkbox"/> Autoimmune                               |
| <input type="checkbox"/> Anxiety                        | <input type="checkbox"/> Communication Disorder                   |
| <input type="checkbox"/> Autism Spectrum                | <input type="checkbox"/> Deaf/Hearing Impairment                  |
| <input type="checkbox"/> Intellectual                   | <input type="checkbox"/> Speech & Language Impairment             |
| <input type="checkbox"/> Medical and Chronic Health     | <input type="checkbox"/> Specific Learning                        |
| <input type="checkbox"/> Motor                          | <input type="checkbox"/> Substance Abuse (in recovery/treatment)  |
| <input type="checkbox"/> Neurological                   | <input type="checkbox"/> Trauma and Stressor-Related (e.g., PTSD) |
| <input type="checkbox"/> OCD                            | <input type="checkbox"/> Visual Impairment                        |
| <input type="checkbox"/> Orthopedic/Mobility Impairment | <input type="checkbox"/> Other(s):                                |
| <input type="checkbox"/> Physical (Spinal Cord, TBI)    | _____   |
| <input type="checkbox"/> Psychological or Psychiatric   | _____   |
|   | _____   |

**Describe how your disability impacts you in the academic and physical environments:** \_\_\_\_\_

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**Have you received any treatments or interventions in the past and/or presently, including medications and side effects?** \_\_\_\_\_

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**Please check which accommodation(s) and services that you are requesting. Please note that accommodations are based on functional impact of the disability/impairment and individualized:**

- |  |   |
|--|---|
| <input type="checkbox"/> Priority registration   | <input type="checkbox"/> Reader for exams                     |
| <input type="checkbox"/> Ability to type exams   | <input type="checkbox"/> Scribe for exams                     |
| <input type="checkbox"/> Alternate format of texts   | <input type="checkbox"/> Spell checker                        |
| <input type="checkbox"/> ASL and/or CART   | <input type="checkbox"/> Thesaurus                            |
| <input type="checkbox"/> Exams administered in reduced distraction environment/private testing | <input type="checkbox"/> Dictionary                           |
| <input type="checkbox"/> Extended time for exams   | <input type="checkbox"/> Type well                            |
| <input type="checkbox"/> Note-taking services  | <input type="checkbox"/> Use of assistive technology for exam |
| <input type="checkbox"/> Permission to record lectures   | <input type="checkbox"/> Assistive Technology                 |
| <input type="checkbox"/> Early access to course content  | <input type="checkbox"/> Use of calculator on exam            |
| <input type="checkbox"/> Permit breaks   | <input type="checkbox"/> Other(s):                            |
| <input type="checkbox"/> Preferential Seating  | _____   |
| <input type="checkbox"/> Accessible furniture  | _____   |
| <input type="checkbox"/> Reduced courseload  | _____   |

**Briefly describe why you are requesting the accommodations that you checked off in the prior question:**

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**Have you received accommodations at previously attended universities?** YES  NO

**If YES, please indicate the accommodations and which university:** \_\_\_\_\_

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**Did you have an Individual Education Plan (IEP) in high school?** YES  NO

**If employed, do you receive accommodations at work?** YES  NO

If YES, please indicate: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Support Services**

Please check if you receive support from any of the following programs.

Internal Services

- City College Academy for Professional Preparation (CCAPP)
- Counseling Center – Marshak J15
- Emergency Grants/ Scholarships
- Macaulay Honors College
- Psychological Center – NAC 8/101
- Search for Education, Elevation and Knowledge (SEEK)
- Retention, Achievement, Professionalism Success Institute (RAP-SI)
- Student Support Services Program (SSSP)
- Other: \_\_\_\_\_

External Services

- Adult Career and Continuing Education Services- Vocational Rehabilitation (Access- VR)
- Commission for the Blind and Visually Handicapped (CBVH)
- Deaf Services
- Psychiatrist
- Psychologist
- Other: \_\_\_\_\_

**Are you interested in the LEADS Program (Linking Employment Academics & Disability Services) at the AccessAbility Center?** YES  NO

I affirm to the best of my knowledge that the information I have provided in this form is true and accurate. I understand that completing this form is the initial step in the registration process. My request will be reviewed and approved based on the information provided on this form, the self-report from the intake, and supporting documentation.

Student’s Name (Please Print): \_\_\_\_\_  
Date: \_\_\_\_\_

**Student’s Signature:** \_\_\_\_\_

**Voter Registration**

Would you like assistance registering to vote? YES  NO

If YES, AAC has Voter Registration forms and Absentee Ballot applications. Upon request, we will assist you in completing these forms.

**AAC/SDS Use Only**

Date Application Received: \_\_\_\_\_  
Staff Name: \_\_\_\_\_  
Date Reviewed: \_\_\_\_\_

Date: \_\_\_\_\_ EMPL ID: \_\_\_\_\_

Name: \_\_\_\_\_  
*Last First Middle*

Gender:  Male  Female  Another identity (Please specify) \_\_\_\_\_

DOB: \_\_\_\_\_ Email Address: \_\_\_\_\_  
*MM/DD/YY OK to leave a message? Y  N*

Cell Phone: \_\_\_\_\_ Home Phone: \_\_\_\_\_  
*OK to leave a message? Y  N  OK to leave a message? Y  N*

Which way is best to contact you? Cell  Home  Email

Address: \_\_\_\_\_ Apt: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
*OK to send mail? Y  N*

Do you currently reside in The Towers Residence Hall? YES  NO

How long have you lived at your current address? (If you live in the Towers, please list number of years at your permanent or mailing address.) \_\_\_\_\_

Is this a stable situation? YES  NO  Unsure

Would you like to consult with someone about housing, food or other basic necessities? YES  NO  Unsure

**Emergency Contact Information**

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Cell Phone: \_\_\_\_\_ Home Phone: \_\_\_\_\_

**Relationship Status:**

- Single
- Married
- Separated
- Divorced
- Domestic Partnership
- Living together
- Widowed

**Race/ Ethnicity** (Please Check):

- American Indian, Alaskan Native or Native Hawaiian
- Asian or Pacific Islander
- Biracial or Multiracial
- Black or African American
- Caucasian/ White
- Hispanic or Latino-a
- Prefer not to answer
- Other (Please Specify) \_\_\_\_\_

## **Employment Background**

Are you currently employed? YES  NO

If YES, please list the name of your employer \_\_\_\_\_ and your job title \_\_\_\_\_  
(Please note that your employer will not be contacted).

If employed, how many hours do you work each week?

- |  |   |
|--|---|
| <input type="checkbox"/> I am not employed | <input type="checkbox"/> 21-30 hours        |
| <input type="checkbox"/> 1-10 hours        | <input type="checkbox"/> 31-40 hours        |
| <input type="checkbox"/> 11-20 hours       | <input type="checkbox"/> More than 40 hours |

Have you ever served on active duty in the US Armed Forces, Reserves, or National Guard?

- Never served in the military  
 Only on active duty for training in the Reserves or National Guard  
 Currently on active duty  
 On active duty in the past, but not now

## **International Student Status**

Are you a U.S. Citizen? YES  NO

Are you an International Student? YES  NO  If YES, what is your country of Origin: \_\_\_\_\_

## **HEALTH INSURANCE**

Do you have Health Insurance: YES  NO  Unsure

U.S based  International  Name of the Insurance carrier: \_\_\_\_\_  
(Your health insurance company will not be billed or contacted)

If YES, what is the name of the person who holds your health insurance policy? (Fill in your own name if you hold the policy): \_\_\_\_\_

What is the relationship of the person who holds the policy to you? (Write 'self' if you hold the policy): \_\_\_\_\_

If NO, do you need help connecting with an Insurance Navigator? YES  NO

## **Educational Information**

First semester at CCNY (ex. Spring 2013): \_\_\_\_\_

How many credits have you accumulated so far? \_\_\_\_\_

Current Year Status:

- |   |   |
|---|---|
| <input type="checkbox"/> 1 <sup>st</sup> year Undergraduate | <input type="checkbox"/> 5 <sup>th</sup> year Undergraduate |
| <input type="checkbox"/> 2 <sup>nd</sup> year Undergraduate | <input type="checkbox"/> Graduate or Professional           |
| <input type="checkbox"/> 3 <sup>rd</sup> year Undergraduate | <input type="checkbox"/> Not seeking a degree               |
| <input type="checkbox"/> 4 <sup>th</sup> year Undergraduate |   |

Are you a transfer student? YES  NO

If yes, please list the name, city, state and country of any college or University you have attended previously: \_\_\_\_\_

What is your enrollment status this semester?

Full-time

Part-time

CCNY student not currently enrolled

Family member, friend, partner, spouse, etc of CCNY student

School/Major: \_\_\_\_\_ Overall GPA: \_\_\_\_\_

Anticipated semester and year of graduation (ex. Spring 2016): \_\_\_\_\_

Do you attend the Center for Workers Education (CWE)? YES  NO

Name of High School Attended: \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Country \_\_\_\_\_

Date H.S. Diploma received (MM/YY): \_\_\_\_\_ **OR** Date GED received (MM/YY): \_\_\_\_\_

Please list any degrees you have earned at other colleges/ universities: \_\_\_\_\_

**How did you hear about our services/ who referred you? (Check all that apply)**

Friend

Family

Advisor

Website

Professor

Flyer

Email

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