



# Guide to Requesting Accommodations

# How to Apply for Accommodations

**Welcome Tornado!** Your adventure of faith, learning, and life-changing experiences is about to begin!

The team in the Office of Accessibility Services will guide you through the registration process and facilitate your access to learning and campus experiences.

## Who is Eligible?

Under the ADA Amendments Act of 2008 and Section 504 of the Rehabilitation Act of 1973, individuals with disabilities are protected from discrimination and may be entitled to reasonable accommodations. Students at Concordia University Texas (CTX) are responsible for self-identifying their disability to the Office of Accessibility Services (OAS). Supporting documentation may be requested to understand the functional impacts of the disability. Once eligibility has been verified, the OAS will coordinate with students, faculty, and staff to arrange services and accommodations to ensure equal access to our educational programming and activities.

## How do I Apply?

Students seeking accommodations for disability-related impacts on their education and campus life experience should complete the [Accommodations Request Form](#). It is recommended to submit supporting documentation during registration to verify disability status. The OAS may request supporting or additional documentation during their review, on a case-by-case basis, to better understand the functional impacts of the disability. If students need to request documentation from a licensed provider, the OAS has provided the [CTXOAS Medical Verification Form](#), [CTXOAS Mental Health Verification Form](#), and the [CTXOAS Emotional Support Animal Request Form](#) as a courtesy. Recommendations from licensed providers will be considered, but they do not guarantee accommodations.

### Helpful Types of Documentation:

- 504, IEP, or MTSS Plan from High School
- FIE or Diagnostic Assessments
- Medical Records
- [CTXOAS Medical Verification Form](#)
- [CTXOAS Mental Health Verification Form](#)
- [CTXOAS Emotional Support Animal Request Form](#)

## How do I Apply? (continued)

Once the OAS has received and reviewed all necessary information, a member of the Office of Accessibility Services staff will reach out via email to the student's ctx.edu email account or by phone to schedule a meeting to discuss the accommodation request. Generally, this meeting's outcome will be a written agreement of services and accommodations offered by the university or reasons for denying the request.

Incoming freshman and transfer students are encouraged to reach out to the OAS before beginning classes so that there is ample time to arrange all needed accommodations. This also provides time in case additional documentation is needed to verify eligibility.

## Review of Registration Steps

- 1 Complete the [Accommodations Request Form](#) with current supporting documentation.  
*(Medical Records, School Records, Forms Provided by the OAS, etc.)*
- 2 Watch your ctx.edu email for communication from the OAS about your request.  
*(Request for more information or to schedule a meeting)*
- 3 Meet with the OAS.
- 4 Start or continue your academic adventure at CTX
- 5 Stay connected with the OAS about your accessibility needs each semester.

## Why Could My Request Be Denied?

Concordia University Texas reserves the right to deny requests for services or accommodations if the student has not established a reasonable connection between his/her disability and the need for an accommodation. If the documentation provided by a student does not support the existence of a disability or the need for an accommodation, the student will be so advised. Students will be given the opportunity to supplement the initial documentation with further information from a specialist in their disability. The university is not required to provide an accommodation that compromises the essential requirements of a course or program, imposes an undue administrative or financial burden based on the university's overall institutional budget, or poses a direct threat to the health or safety of others.

## Can I Appeal?

Concordia University is committed to providing reasonable accommodations to qualified individuals with disabilities and to protecting students with disabilities from discrimination or retaliation. An appeal procedure is available for students who believe that they have not received reasonable accommodations and services or have been discriminated against. The OAS collaborates with students and faculty to establish reasonable accommodations and address any complaints that may arise. A student who disagrees with a determination of eligibility or the accommodations offered is encouraged to meet first with the senior leader of the Office of Accessibility Services.

If a resolution cannot be reached between the student and the Office of Accessibility Services, the complaint may be escalated to university leadership. The Vice President of Academic Operations at Concordia University Texas is designated as the Section 504/ADA Compliance Officer and will handle complaints related to students with disabilities. Written complaints should include the student's name and address, as well as a detailed description of the problem or concern. The complaint should be filed within thirty (30) days of the student becoming aware of the problem or concern, and submitted to:

*KC Pospisil, Vice President of Academic Operations*

*Concordia University Texas*

*11400 Concordia University Dr.*

*Austin, Texas 78726*

The Vice President of Academic Operations will meet with the student, other university officials, or other interested parties to investigate the complaint. This investigation shall be informal yet thorough, affording all interested parties an opportunity to submit evidence relevant to the complaint. Within thirty (30) days, the Vice President of Academic Operations will issue a written determination of the complaint's validity and a description of any needed resolution(s) to the involved parties.

A complaint may also be filed with:

*Office of Civil Rights, U.S. Department of Education*

*400 Maryland Avenue, S.W.*

*Washington, D.C. 20202-1100*

*(800) 421-3481 **TTD: (877) 521-2172** [OCR@ed.gov](mailto:OCR@ed.gov)*



11400 Concordia University Dr., Austin, TX 78726 512.313.4302

## **Request for Accessibility Services Verification Form:**

*Physical or Medical Disabilities*

Under the ADA Amendments Act of 2008 and Section 504 of the Rehabilitation Act of 1973, individuals with disabilities are protected from discrimination and may be entitled to reasonable accommodations. Concordia University Texas's Office of Accessibility Services (OAS) works with students, healthcare providers, faculty, and staff to arrange services and accommodations to ensure equal access to educational programming and activities. To coordinate these services, current and comprehensive medical documentation from a licensed healthcare provider unrelated to the student may be requested on a case-by-case basis to understand the scope and severity of the disability. Federal disability laws classify a disability as an impairment that substantially limits one or more major life functions; such as walking, seeing, hearing, breathing, eating, caring for oneself, performing manual tasks, and working ([ADAAA Sec. 12102](#)). The OAS will make all determinations on the eligibility for accessibility services and grant the appropriate accommodations to achieve the goal of equal access. The OAS values the consultation given by healthcare providers on their accessibility recommendations in the post-secondary education setting. Requests for additional information may be necessary.

***This box is to be completed by the student.***

Student's Full Name: \_\_\_\_\_

Student's ID Number: B00\_\_\_\_\_

I, \_\_\_\_\_, authorize my healthcare provider below to release to Concordia University Texas's Office of Accessibility Services the relevant medical information requested on this form for the purpose of determining appropriate accommodations for my permanent or temporary disability while a student at Concordia University Texas.

Student's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

***The rest of the form is to be completed by the healthcare provider.***

*All items are required. Please print legibly. Include additional pages, if necessary.*

Provider's Name: \_\_\_\_\_

Specialty: \_\_\_\_\_ License Information: \_\_\_\_\_

Practice Name: \_\_\_\_\_ Practice Phone: \_\_\_\_\_

Practice Address: \_\_\_\_\_

Practice Email: \_\_\_\_\_

# Medical History Documentation

Student's Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Diagnosis or ICD-10 code: \_\_\_\_\_

Date of Dx: \_\_\_\_\_ **[Use additional forms for other Dx(s) for this student.]**

Severity of Condition: ☐ Mild ☐ Moderate ☐ Severe ☐ In Remission

Please describe the symptoms of this disability, when in an active state, including frequency and duration, if applicable: \_\_\_\_\_

\_\_\_\_\_

Current treatment plan and/or medication(s): \_\_\_\_\_

\_\_\_\_\_

Functional limitation(s) and/or impact caused by this disability, or its treatment, on the daily living of this student: \_\_\_\_\_

\_\_\_\_\_

Recommendations for disability management within the post-secondary school setting:

*[Must be clearly linked to the functional limitation(s)/impact.]*

\_\_\_\_\_

Anticipated prognosis and planned medical follow-up appointments: \_\_\_\_\_

\_\_\_\_\_

Provider's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Provider's Printed Name: \_\_\_\_\_





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## **Request for Accessibility Services Verification Form:**

### *Mental Health or Cognitive Disabilities*

Under the ADA Amendments Act of 2008 and Section 504 of the Rehabilitation Act of 1973, individuals with disabilities are protected from discrimination and may be entitled to reasonable accommodations. Concordia University Texas's Office of Accessibility Services (OAS) works with students, healthcare providers, faculty, and staff to arrange services and accommodations to ensure equal access to educational programming and activities. To coordinate these services, current and comprehensive medical documentation from a licensed healthcare provider unrelated to the student may be requested on a case-by-case basis to understand the scope and severity of the disability. Federal disability laws classify a disability as an impairment that substantially limits one or more major life functions; such as walking, seeing, hearing, breathing, eating, caring for oneself, performing manual tasks, and working ([ADAAA Sec. 12102](#)). The OAS will make all determinations on the eligibility for accessibility services and grant the appropriate accommodations to achieve the goal of equal access. The OAS values the consultation given by healthcare providers on their accessibility recommendations in the post-secondary education setting. Requests for additional information may be necessary.

#### ***This box is to be completed by the student.***

Student's Full Name: \_\_\_\_\_

Student's ID Number: B00\_\_\_\_\_

I, \_\_\_\_\_, authorize my healthcare provider below to release to Concordia University Texas's Office of Accessibility Services the relevant medical information requested on this form for the purpose of determining appropriate accommodations for my permanent or temporary disability while a student at Concordia University Texas.

Student's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

#### ***The rest of the form is to be completed by the healthcare provider.***

*All items are required. Please print legibly or type. Include additional pages, if necessary.*

Provider's Name: \_\_\_\_\_

Specialty: \_\_\_\_\_ License Information: \_\_\_\_\_

Practice Name: \_\_\_\_\_ Practice Phone: \_\_\_\_\_

Practice Address: \_\_\_\_\_

Practice Email: \_\_\_\_\_

# Mental Health History Documentation

Student's Name: \_\_\_\_\_ DOB: \_\_\_\_\_

## Diagnosis

DSM-5 Diagnosis/Diagnoses [or ICD-10 code(s)]: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Are there any pending diagnoses? \_\_\_\_\_

\_\_\_\_\_

Date of Dx: \_\_\_\_\_ Date of First Contact: \_\_\_\_\_

Date of Last Contact: \_\_\_\_\_ Frequency of Contact: \_\_\_\_\_

Have you consulted with any other medical professionals? ☐ Yes ☐ No

If yes, please provide the name(s) and the date(s) of contact: \_\_\_\_\_

\_\_\_\_\_

In addition to the DSM-5 diagnostic criteria, what other data was collected to assist your arrival at the diagnosis?

- ☐ Behavioral Observations
- ☐ Developmental History
- ☐ Rating Scales (Beck Depression Scale, etc.)
- ☐ Medical History
- ☐ Structured or Unstructured clinical interview with the student
- ☐ Interviews with others (parents, teachers, spouse, significant other)
- ☐ Neuropsychological or psycho-educational testing, etc. (Dates: \_\_\_\_\_)
- ☐ Other: \_\_\_\_\_

What methods/tools were utilized to assess functional limitations? Please list or attach documentation as needed. \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_





## Relevant History

Are you prescribing this student take any medications currently?

☐ Yes ☐ No ☐ Not the prescribing physician

If yes, please describe the current treatment plan and the impact of the medication on the student's ability to participate in the educational setting. \_\_\_\_\_

\_\_\_\_\_

Has the student ever been hospitalized, received in-patient care, or harmed themselves or others as a part of this diagnosis?

☐ Yes ☐ No

If yes, please provide the dates and further details. \_\_\_\_\_

\_\_\_\_\_

Is there evidence of previous treatment by a healthcare professional?

☐ Yes ☐ No

If yes, please explain your reasoning. \_\_\_\_\_

\_\_\_\_\_

## Symptom Assessment

Describe how the student is substantially limited by the symptoms of their diagnosis in their daily life. (See the following pages for a list, if needed) \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Describe how the student will face substantial limitations in the post-secondary setting.

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

## Symptom Assessment (continued)

Please rate the frequency, duration, and severity of the **relevant symptoms** of this diagnosis.

**Frequency Scale:** How frequently do symptoms occur?

**0**=Never      **1**=Rarely      **2**=Intermittently      **3**=Frequently

**Duration Scale:** How long has the student experienced these symptoms?

**1**=Recent/Acute Onset      **2**=Months      **3**=More than 1 Year

Mental Health Symptoms	Frequency Scale 0-3 (See scale above)	Duration Scale 1-3 (See scale above)	Severity (Check one)			N/A	Comments (Use additional pages for more space)
			Mild	Moderate	Severe		
Anxious Mood							
Compulsive Behaviors							
Delusions							
Depressed Mood							
Disordered Eating							
Fatigue/Loss of Energy							
Hallucinations							
Hypomania							
Impulsive Behaviors							
Panic Attacks							
Phobia, Specify Below: _____							
Obsessive Thoughts							
Racing Thoughts							
Self-Injurious Behavior							
Suicidal Ideation							
Suicide Attempts							
Unable to Leave House							
Other, Specify Below: _____							
Other, Specify Below: _____							

## Symptom Assessment (continued)

Please rate the frequency, duration, and severity of the **relevant symptoms** of this diagnosis.

**Frequency Scale:** How frequently do symptoms occur?

**0**=Never      **1**=Rarely      **2**=Intermittently      **3**=Frequently

**Duration Scale:** How long has the student experienced these symptoms?

**1**=Recent/Acute Onset      **2**=Months      **3**=More than 1 Year

Physiological Symptoms	Frequency Scale 0-3 (See scale above)	Duration Scale 1-3 (See scale above)	Severity (Check one)			N/A	Comments (Use additional pages for more space)
			Mild	Moderate	Severe		
Chest Pain							
Dizziness							
Fainting							
G.I. Distress							
Migraines/Headaches							
Nausea							
Shortness of Breath							
Tachycardia							
Other, Specify Below: _____							
Other, Specify Below: _____							

## Functional Impact Assessment (Post-secondary Setting)

Please rate the frequency, duration, and severity of the ***functional limitations relevant*** to this diagnosis.

**Frequency Scale:** How frequently do limitations occur?

**0**=Never      **1**=Rarely      **2**=Intermittently      **3**=Frequently

**Duration Scale:** How long has the student experienced these limitations?

**1**=Recent/Acute Onset      **2**=Months      **3**=More than 1 Year

Life Activities	Frequency Scale 0-3 (See scale above)	Duration Scale 1-3 (See scale above)	Severity (Check one)			N/A	Comments (Use additional pages for more space)
			Mild	Moderate	Severe		
Caring for oneself							
Communicating							
Concentrating							
Following Directions							
Hearing							
Initiating Activities							
Interacting with Others							
Managing Tasks							
Memorizing							
Organizing							
Persisting							
Problem Solving							
Sitting							
Sleeping							
Standing							
Sustained Reading							
Sustained Writing							
Thinking							
Other, Specify Below: _____							
Other, Specify Below: _____							

### Anticipated Progress/Prognosis

What is the anticipated prognosis of the diagnosis over the course of the student's lifetime?

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What progress have you seen while the student has been under your care?

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Please provide any information on environmental triggers or cyclical patterns observed during the student's treatment.

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### Recommended Accommodations

Please provide recommendations for disability management within the post-secondary setting.

*(Each recommendation must be clearly linked to a functional limitation or impact.)*

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### Clinician Signature

Provider's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Provider's Printed Name: \_\_\_\_\_



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## **Request for Accessibility Services Verification Form:**

### *Emotional Support Animals in University Housing*

Under the Fair Housing Amendments Act of 1998, students at Concordia University Texas (CTX) may be eligible for the reasonable accommodation of an emotional support animal (ESA) in University Housing. The U.S. Department of Housing and Urban Development (HUD) defines an ESA as "a dog, cat, small bird, rabbit, hamster, gerbil, other rodent, fish, turtle, or other small, domesticated animal that is traditionally kept in the home" and "provides therapeutic emotional support" ([Notice FEHO-2020-01](#)). To determine eligibility, CTX's Office of Accessibility Services (OAS) requires documentation from the student's treating healthcare provider concerning their current condition, functional limitations, and direct connection of recommended accommodation and remediation of functional limitations. This provider must not be the student's relative and should be thoroughly familiar with the student's condition and functional limitations. On a case-by-case basis, the OAS may request additional documentation to determine reasonable accommodations. Following city ordinances, documentation about the animal's health will be collected depending on the type of animal requested for the ESA.

#### ***This box is to be completed by the student.***

Student's Full Name: \_\_\_\_\_

Student's ID Number: B00 \_\_\_\_\_

I, \_\_\_\_\_, authorize my healthcare provider below to release to Concordia University Texas's Office of Accessibility Services the relevant medical information requested on this form for the purpose of determining appropriate accommodations for my permanent or temporary disability while a student at Concordia University Texas.

Student's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

#### ***The rest of the form is to be completed by the healthcare provider.***

*All items are required. Please print legibly or type. Include additional pages, if necessary.*

Provider's Name: \_\_\_\_\_

Specialty: \_\_\_\_\_ License Information: \_\_\_\_\_

Practice Name: \_\_\_\_\_ Practice Phone: \_\_\_\_\_

Practice Address: \_\_\_\_\_

Practice Email: \_\_\_\_\_

# Current State of Disability Documentation

Student's Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Date of Initial Visit: \_\_\_\_\_ Date of Last Visit: \_\_\_\_\_

Frequency of Contact: \_\_\_\_\_ Date of Dx (if known): \_\_\_\_\_

In addition to the DSM-5 diagnostic criteria, what other data were collected to assist your diagnosis? \_\_\_\_\_  
\_\_\_\_\_

Current Severity of Condition/Disorder: ☐ Mild ☐ Moderate ☐ Severe ☐ In Remission

Current Prognosis of Condition/Disorder: ☐ Good ☐ Fair ☐ Poor

Does the severity and prognosis of this condition/disorder significantly limit one or more major life activities? ☐ Yes ☐ No

If yes, please describe: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Recommendations for disability management within the post-secondary school setting:

*[Must be clearly linked to the functional limitation(s).]*

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Describe the type of ESA requested. *(Please include information about name, breed, weight, age, etc.)*

\_\_\_\_\_  
\_\_\_\_\_

Provider's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Provider's Printed Name: \_\_\_\_\_

