

## REQUEST FOR REASONABLE ACCOMMODATIONS/MODIFICATIONS

*This page is to be completed by the Applicant/Participant*

Head of Household/Applicant Name \_\_\_\_\_

Address \_\_\_\_\_

City/State \_\_\_\_\_

Telephone/Message Number \_\_\_\_\_

I, \_\_\_\_\_ am requesting a reasonable accommodation from the Cheyenne Housing Authority (CHA) for; *please be specific and detailed as to what you are requesting is medically necessary for equal opportunity to use and enjoy your housing unit: (This section to be completed by applicant/participant):*

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

**Dear Qualified Individual (i.e. doctor or other medical professional, peer support group, non-medical service agency, or reliable third party who is in a position to know about the individual's disability),**

I hereby authorize you to provide the information requested on this form and return to:

Cheyenne Housing Authority  
PO Box 20046  
Cheyenne, WY 82003  
Phone: 307-633-8333  
Fax: 307-633-8315

Head of Household/Applicant Signature \_\_\_\_\_

Date \_\_\_\_\_

*Although this form requests that you provide information relating to the requested accommodation of the Applicant/Participant, you are not requested to identify the specific nature of or the severity of the Applicant's/Participant's claimed disability.*

**STOP: QUALIFIED INDIVIDUALS COMPLETE THE FOLLOWING**

***This page is to be completed by the Qualified Individual signing this page  
(Not the applicant/participant)***

1. In my opinion, the Applicants/Participant has a disability      Yes      No      N/A

Disability in this context is defined as:

- a. A physical or mental impairment that substantially limits one or more major life activities
- b. A record of having such impairment
- c. Being regarded as having such impairment

2. In my **opinion**, the Applicant's/Participant's disability requires a reasonable accommodation or type of adaptation ***medically necessary*** as a direct result of the Applicant's/Participant's disability to ensure the Applicant/Participant has equal opportunity to use and enjoy his or her housing unit. **(If, in your opinion, no accommodations are necessary, please indicate this by writing "None")**.

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3. Please describe the relationship between the Participant/Applicant's disability and the need for the requested accommodation/modification:

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Signature

Title

Date

Name (Please Print)

Telephone Number

Address

City, State, ZIP

Agency/Institution/Organization