

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").

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

Signature

Title

Date

Name (Please Print)

Telephone Number

Address

City, State, ZIP

Agency/Institution/Organization