Verification of Status as a person with a Disability and Need

Housing Provider: Name: Crossed Arrows Real Estate Services
Address: P.O. Box 2840
City/State/Zip: Cheyenne, WY 82003

Name of Tenant/Applicant/Guest Requesting a Reasonable Accommodation or Modification:

_____

The tenant, guest, or applicant listed above requires the reasonable accommodation or modification described in the attached request because of limitations arising from a disability. State and federal laws require housing providers to make reasonable accommodations to rules, policies, procedures, or services when such changes are not an undue financial **and** administrative burden, or fundamental alteration to a housing program.

The Fair Housing Act as Amended in 1988 defines "disability" as a physical or mental impairment that substantially limits one or more major life activities. Wyoming law defines a "person with disability" as an individual who has a mental or physical impairment which substantially limits one or more life activities.

The term **"major life activity"** means those functions such as caring for one's self, performing manual tasks, walking, seeing, hearing, speaking, breathing, learning and working (24 C.F.R. § 100.201(b) and Wyo. Stat. Ann. § 35-13-205(a)(iii)).

IMPORTANT: The health care provider certifying the disability and need for an accommodation and/or modification **IS NOT** required to reveal the specific nature and/or severity of the individual's disability, **NOR** specific information about treatment. However, there must be an identifiable relationship between the request and the individual's disability.

Under Wyoming law, a person who knowingly and intentionally misrepresents that an animal is a service or assistance animal is guilty of a misdemeanor and may be fined not more than seven hundred fifty dollars ($750.00). WYO. STAT. § 35-13-203(b).

As a health care provider with the knowledge necessary to make a determination, I am able to advise that

_____

(name of client)

qualifies as an individual with a disability, experiencing permanent or long-term impacts of an impairment substantially limiting major live activities. The following accommodation or modification is consistent with the needs associated with his/her disability and the expected duration of the disability.

Accommodation/ Modification Requested:

_____

_____

Please describe the <u>major life activities</u> limited by the disability that specifically relate to the need for the request for a reasonable accommodation or modification:

Examples: sleeping, learning, eating, walking, seeing, working, talking, caring for ones self, etc.

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Please describe how this request will ameliorate the limitations of the major life activities referenced above so that an equal opportunity to use and enjoy the premises is available:

Example: Dog alerts client to oncoming seizures, allowing time to take medication and reach a safe environment.

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_____

_____

Signature of Health Care provider

_____

Printed Name and Title

Phone Number: _____

Date:_____