



**COLORADO**  
 Department of Health Care  
 Policy & Financing

504/ADA Coordinator  
 1570 Grant Street  
 Denver, Colorado 80203  
 Telephone: 303-866-6010  
 FAX: 303-866-2828  
 State Relay: 711

Email: [hcpf504ada@state.co.us](mailto:hcpf504ada@state.co.us)

# Reasonable Modification Request Form

*Please fill out this form completely in print or type. Sign and return to the 504/ADA Coordinator via mail, fax or email. Requests are processed as quickly as possible. Timing may vary depending on the nature and complexity of the request. If you require assistance completing this form, please contact the 504/ADA Coordinator.*

## Qualified Individual Information

FIRST NAME		LAST NAME	
HOME PHONE (Please include area code)		WORK or CELL PHONE (Please include area code)	
MAILING ADDRESS			CITY
STATE	ZIP CODE	EMAIL ADDRESS (If available)	

## How would you like us to contact you?

Email      Mail      In Person      Telephone      Other \_\_\_\_\_

**Please describe the requested modification and provide any supporting documentation necessary to assist in processing the request. Attach additional pages if needed.**

**Please sign and date this request. You do not need to sign if submitting this form by email, just type your name.**

\_\_\_\_\_  
**Signature** \_\_\_\_\_  
**Date**  
*Parent or Legal Guardian may sign on behalf of minor child.*  
*Legal Guardian, Power of Attorney, or equivalent may sign on behalf of adult documentation is required.*

**For Administrative Use Only:**

Action taken: \_\_\_\_\_ Date received \_\_\_\_\_

\_\_\_\_\_  
**ADA Coordinator signature** \_\_\_\_\_  
**Date completed**