



## REQUEST FOR REASONABLE ACCOMMODATION

NAME: \_\_\_\_\_

TELEPHONE NO.: \_\_\_\_\_

ADDRESS : \_\_\_\_\_

CITY, STATE, ZIP CODE: \_\_\_\_\_

PROGRAM: PUBLIC HOUSING: \_\_\_\_\_ SECTION 8: \_\_\_\_\_ ARE YOU AN APPLICANT?  YES  NO

1. The following member of my household has a disability, i.e., a physical or mental impairment that substantially limits one or more life activities such as caring for one's self, doing manual tasks, walking, seeing, hearing, breathing, learning and working.

Name: \_\_\_\_\_ Relationship or association with you: \_\_\_\_\_

2. As a result of this disability, I am requesting the following accommodation: (Please check one or more boxes below):

PUBLIC HOUSING RESIDENTS ONLY: A change in my apartment or the public or commons areas of the housing development. Please explain why the requested change is necessary and specifically state the change you are requesting: \_\_\_\_\_  
\_\_\_\_\_

An exception to a rule, policy, practice or service. (You may request a change that you believe will allow you to comply with the terms of the lease or voucher, but everyone is required to comply with the essential terms of their lease or the voucher program.) Please explain why the exception you are requesting is necessary, and specifically identify the exception you want HACSL to make.  
\_\_\_\_\_  
\_\_\_\_\_

Other. Please specify: \_\_\_\_\_  
\_\_\_\_\_

3. This accommodation is necessary so that I can: (Please state how the accommodation will provide you with an equal opportunity to participate in, or benefit from, HACSL housing programs.)

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



4. I authorize HACSL to verify that I have a disability and need the accommodation I have requested. In order to verify this information, HACSL may contact the following medical or mental health professional, or licensed service agency whose function is to provide services to the disabled, or other expert in the field of:

<p><b>REQUIRED INFORMATION:</b></p> <p>Name: _____</p> <p>Title of Professional or Expert : _____</p> <p>Agency, Facility or Institution (if any): _____</p> <p>Address: _____</p> <p>City, State, Zip Code: _____</p> <p>Telephone: _____ Fax: (required) _____</p>
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**NOTE: HACSL requires the above information. Please have your health care provider complete the Health Care Provider form and attach it to this request.**

Complete the following, if applicable:

I authorize HACSL to contact the following individual who assisted me in the completion of this form:

Name: \_\_\_\_\_

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

City, State, Zip Code: \_\_\_\_\_

Telephone: \_\_\_\_\_

***I understand that the information obtained by HACSL will be kept completely confidential, to the extent permitted by law, and used solely to make a determination regarding my accommodation request. I further understand that HACSL will not process my request if this form is incomplete or has been altered, or does not have my original signature.***

Signed: \_\_\_\_\_  
(Head of Household or Authorized Representative)

Date: \_\_\_\_\_

Signed: \_\_\_\_\_  
(Individual with the Disability, if Over 18)

Date: \_\_\_\_\_

**This form and the completed Health Care Provider Verification form must be submitted to the 504 Coordinator, Janice Kimball, Housing Authority of the County of Salt Lake, 3595 South Main Street, Salt Lake City, UT 84115.**

If you have any questions regarding this form, please contact your Eligibility Specialist, Property Manager or Section 8 Housing Specialist.

