Housing Authority of the City of Heber Springs
400 E. Spring St. P.O. Box 900 Heber Springs, AR 72543 |Phone: 501.362.6108|Fax: 501.362.7818| www.hspha.com

REQUEST FOR REASONABLE ACCOMMODATION

NAME: ______________________________

ADDRESS: ______________________________

PHONE: ______________________________

1. The following member of my household has a disability as defined below: (Disability defined as a physical or mental impairment that substantially limits one or more life activities; or a record of having such an impairment; or regarded as having such an impairment)

   Name: ______________________________

   Relationship or association with you: ______________________________

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

   - ❑ A change in my apartment or other part of the housing development. Please specify:

     ____

     ____

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   - ❑ A change in the following rule, policy or procedure. (Note that a change in how to meet the terms of the lease may be requested, but the terms of the lease must be met.) Please specify:

     ____

     ____

     ____

   - ❑ Other (for example, a change in the way the HSHA communicates with you). Please specify:

     ____

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     ____

3. This request for reasonable accommodation is necessary so that I can: (Please Specify)

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    ____

    ____

4. I authorized the Housing Authority of the City of Heber Springs to verify that I have a disability and have the need for the reasonable accommodation I have requested. In order to verify this information the HSHA may contact via mail, telephone, or in person the following physician, psychiatrist, licensed psychologist, licensed nurse practitioner, licensed social worker, rehabilitation professional, nonmedical service agency whose function is to provide services to the disabled, or other expertise in the field of:

    ____

Name: ____

Title of professional or expert: ____

Agency, Facility or Institution (if any): ____________________________________

Address: ____

Telephone: ____

I understand that the information obtained by the HSHA, will be kept completely confidential and used solely make a determination on my reasonable accommodation request.

Please return this form promptly as possible so that the HSHA may make a determination on this request.

Signed: ________________________________ Date: ________________

Witness: _______________________________ Date: ________________

If on behalf of a minor child, please indicate whether you are the parent or guardian. Where the individual with the disability is over 18 and is not the head of household, he or she should sign the authorization for verification.