



HOUSING ASSISTANCE PAYMENT (HAP) ADJUSTMENT REQUEST FORM

(This form must be used for any actions requiring an adjustment  
exceeding 60 days)

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

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

Last 4 of SSN: \_\_\_\_\_

Owner #: \_\_\_\_\_

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

Adjustment Type: ☐ Increase ☐ Decrease \_\_\_\_\_

Payment Type: ☐ HAP ☐ Payment to Participant (URP, Overpayment, Other)

Adjustment Amount: \$ \_\_\_\_\_

Payment Period: From \_\_\_\_\_ To: \_\_\_\_\_

Reason for Adjustment:

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HCV Staff: \_\_\_\_\_

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

Supervisor/Operations Manager: \_\_\_\_\_

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