Reset

NEW YORK CITY HOUSING AUTHORITY
APPLICATIONS AND TENANCY ADMINISTRATION DEPARTMENT

A. Case #

B. **Re: REASONABLE ACCOMMODATION VERIFICATION LETTER**

C. Dear Applicant:

You have indicated that you or a member of your household requires an accommodation because of a health condition. We need to verify this information with either a health care provider or social worker.

This information is not used in determining whether you are eligible for an apartment. It is only used to determine whether you are entitled to the requested accommodation.

The family member with the health condition (or his/her parent or legal guardian) should review this form and sign the authorization below then give the form to their health care provider or social worker.

The New York City Housing Authority will use this information **only** for the purpose of offering you an apartment which accommodates your needs and will keep it confidential pursuant to law. If you choose not to authorize the release of this information, we will no longer consider your request for a reasonable accommodation.

D. AUTHORIZATION TO RELEASE INFORMATION

1. TO: _____

2. Name of Social Worker or Health Care Provider

3. RE: Last _____ First _____ MI ____

Name of Client/Patient

I hereby authorize you to provide the New York City Housing Authority with the information requested on the back of this form about the following health condition. This release shall not constitute a waiver of the confidentiality of our relationship.

4. I wish to receive an (select all that apply)

☐ **Extra Bedroom** ☐ **Lower Floor** ☐ **Retrofitted Apartment**

☐ **Other Accommodation (Explain):** _____

5. _____ 6. *Date* _____ 7. *Signature of Client/Patient or Parent/Legal Guardian* _____ 8. *Relationship to Applicant*

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Case #

Client Name:

HEALTH CARE PROVIDER / SOCIAL WORKER RESPONSE FORM

We would appreciate your cooperation in furnishing the requested information regarding the individual named on the authorization of this form. Please mail the completed form directly to us at the address indicated above.

Your Name

(Last name) *(First name)* *(Title)*

Your Organization

Organization's Address

Office Phone # ( ) –

1. How long has this person been your patient/client?

2. When did you last evaluate this patient/client?

3. Your patient/client has told us (s)he needs an accommodation **(see front of this form)** because of health condition(s).

   Is this true? Yes No

4. Please explain whether your patient/client's requires an accommodation, the accommodation required and how it accommodates the health condition.

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5. Is this health condition temporary?

☐ Yes, please explain and estimate duration ☐ No

6. If your patient/client's requested accommodation is based on a need for medical equipment, please list below all medical equipment currently used by your patient/client :

☐ Yes ☐ No

HEALTH CARE PROVIDER: CERTIFICATION

I certify that the information above is accurate and true to the best of my knowledge.

Name

(Last name) *(First name)* *(Title)*

Signature of Health Care Provider/Social Worker

Date *(mm/dd/yyyy)*

License Number

Health Care Provider: Place Medical Stamp below.