Reset

NEW YORK CITY HOUSING AUTHORITY

DEPARTMENT OF HOUSING APPLICATIONS

☐ **Bronx Applications Office**
1 Fordham Plaza, 5th fl.
Bronx, NY 10458
(718) 329-7859

☐ **Brooklyn Applications Office**
350 Livingston Street, 2nd fl.
Brooklyn, NY 11217
(718) 250-5900

☐ **Manhattan Applications Office**
55 West 125th Street, 7th fl.
New York, NY 10027
(212) 828-7100

☐ **Queens Applications Office**
120-34 Queens Blvd. 2nd fl.
Kew Gardens, NY 11415
(718) 286-7500

☐ **Staten Island Applications Office**
120 Stuyvesant Place, 2nd fl.
Staten Island, NY 10301
(718) 448-7326

Date _____

Application Reference # _____

Dear Sir/Madam:

On _____, _____ received medical care at
Date of hospital admission *Name of patient*

_____ as a victim of domestic violence. The
Name of hospital

patient was admitted as an inpatient and treated for _____,
Type of injuries/condition

_____,
Type of injuries/condition

which patient claims to have been caused by _____,
Name of perpetrator

_____ / _____
Relationship to victim *Address, if known*

during a domestic violence incident on or about _____.
Date of injuries/condition

The patient fears that the perpetrator of the attack has knowledge of the patient's residence which places him/her at continued risk of another attack. The undersigned is of the opinion that due to the patient's injuries/condition, it is in the best interest of the patient/family to be relocated.

Sincerely,

Hospital Personnel _____
Name (Print & Sign) *Title*

Telephone # _____ Date _____ Hospital Stamp or Seal _____