Department of Homeless Services
Department of Social Services

REASONABLE ACCOMMODATION REQUEST FORM

INSTRUCTIONS: Clients must complete Section I and submit this form along with any supporting documentation to the Program/Facility Director, or functional equivalent ("Director"). DHS and provider staff must offer to help the client with completing this form.

Section I: This section must be completed by or with the client.

Name: _____

Facility/Program: _____

Client ID/SSN: _____ Phone: _____

Describe the Accommodation Requested (attach any supporting documentation).

_____

_____

_____

_____

Section II Instructions: Any Director receiving a completed form with disability-related documentation must complete Section II, return a copy to the client, and immediately transmit by email or fax the request and supporting documents to the appropriate Program Administrator. Supporting documentation is not required if the disability is obvious/apparent or otherwise known to DHS.

Section II: To be completed by the Facility Director or designee.

Name/Title: _____

Facility/Program: _____

Address: _____

Phone: _____ Date Received: _____

☐ I discussed the HIPAA form with the client and the client consented to complete a HIPAA form.

☐ I discussed the HIPAA form with the client and the client declined to complete a HIPAA form.

Signature: _____

After completing, provide a copy of this form to the client.

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HIPAA AUTHORIZATION FOR THE DISCLOSURE OF INDIVIDUAL HEALTH INFORMATION

Client Name _____

Date of Birth _____ Case ID Number _____

Last 4 digits of Social Security Number _____

I, or my authorized representative, request that health information about my medical care and treatment be released as outlined below. Federal and state law and regulations, including the Health Insurance Portability and Accountability Act of 1996 (HIPAA) safeguard the privacy of my protected health information (collectively "health records").

Before signing, I understand that:

1. My health records may include confidential **ALCOHOL** and **DRUG ABUSE, MENTAL HEALTH TREATMENT** (except psychotherapy notes), and **HIV-RELATED**[1] **INFORMATION**. This information will only be released if I sign my initials in the appropriate boxes in Item 8(a).
2. I can ask for a list of people who may get or use my HIV-related information without my consent. If I suffer discrimination because of the release of HIV-related information, I may contact the New York State Division of Human Rights at **(888) 392-3644** or the New York City Commission on Human Rights at **(212) 416-0197**. They are in charge of protecting my rights.
3. Signing this form is voluntary. If I do not sign it, my treatment, payment to treatment providers, enrollment in a health plan, and eligibility for shelter will not be affected. But, if I do not sign it and I did not submit documentation with my reasonable accommodation request, my reasonable accommodation request may be denied because the NYC Department of Homeless Services (DHS) did not have any supporting documentation or information to review.
4. I can change my mind at any time except for any information that has already been released. To do so, I must tell my shelter or facility director in writing.
5. My health information shared under this consent may be re-released by DHS. The privacy of this information may no longer be protected by federal or state law.

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[1] Human Immunodeficiency Virus causes AIDS. The New York State Public Health Law protects information which reasonably could identify someone as having HIV symptoms or infection and information regarding a person's contacts.

PERMISSION TO SHARE HEALTH INFORMATION

6. Name and address of health provider or entity to release this information:

_____

_____

_____

7. This health provider will send this information to: **NYC Department of Social Services, Customized Assistance Services, Office of Reasonable Accommodations, 150 Greenwich Street, 30th floor, New York, NY 10007**.

8(a). Information to be released: **Medical records for the entire year prior to the signature date below**. Include *(Indicate by Initialing)*:

☐ Alcohol/Drug Treatment ☐ Mental Health Information ☐ HIV Related Information

8(b). By initialing here _____, I allow _____
(Initials) (Name of individual health care provider)
to discuss my health information with the **NYC Department of Social Services**.

9. Reason for release of information: **<u>At request of Patient</u> for purpose of reasonable accommodation request only**.

10. Expiration date: **One year from the date of signature**

All items on this form have been completed and my questions about this form have been answered. I was given a copy of the form

_____ _____
Signature of Patient or Authorized Representative by Law Date

_____
If not the Patient, name of individual signing form

_____
Authority to sign on behalf of patient

_____
The best phone number to contact me