

## 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<sup>1</sup> 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 **(212) 961-8650** or the New York City Commission on Human Rights at **(212) 306-7450**. 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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<sup>1</sup> 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:

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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: **At request of Patient 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 if individual signing form

\_\_\_\_\_  
Authority to sign on behalf of patient

\_\_\_\_\_  
**The best phone number to contact me**

# INFORMATION ABOUT THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY (HIPAA) CONSENT FORM

This FAQ helps explain the HIPAA consent form and why we are asking you to complete it.

## Why should I complete the HIPAA consent form?

Some Reasonable Accommodation Requests (RAR) need a review to decide if it will be approved. The Office of Reasonable Accommodations (ORA) reviews relevant information from your provider to make this determination. Signing the HIPAA consent lets ORA contact your provider when more information is needed to decide about your request. Signing it saves time in the review process.

## What information will be collected using this form?

ORA will only ask for information related to the Reasonable Accommodation (RA) that you asked for. Staff will not use the form to contact your provider to get any information unrelated to your request.

## How do I complete this form?

- You must fill out, sign, and date the HIPAA consent for it to be valid.
- The HIPAA consent is valid for one year from the date you sign it.
- If you are not able to sign the consent, an authorized representative can sign for you. If an authorized representative is signing for you, you must give us a document that proves their authority, such as a Power of Attorney or Guardianship Commission.

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## INFORMATION ABOUT THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY (HIPAA) CONSENT FORM *(continued)*

### **What if I no longer want ORA to use this form to reach out to my provider?**

You can tell us to stop the use of the form at any time, but you must tell the shelter or facility director in writing.

**Note:** You don't need to sign this consent if you don't want our help getting information from your provider. Instead, you can get relevant information directly from your providers to hand in with your accommodation request.

### **What if I don't have any documentation?**

If you do not have any documentation to submit with the RAR(s), and you do not complete and sign the HIPAA form, your request may be denied because we did not have any supporting documents or information to review.

### **What if I have more questions about this form?**

DHS staff and shelter staff will answer any questions you have about the form and can help you fill it out in person.