Human Resources Administration
Department of Social Services

REQUEST FOR MEDICAL/CLINICAL INFORMATION

You have asked for a reasonable accommodation that requires medical/clinical documentation. Please follow the instructions below**.**

INSTRUCTIONS AND INFORMATION
➢ Please have your provider complete **pages 3 and 4** of this form. We need this information to make a decision about your request for a reasonable accommodation. If you want to send the pages to us yourself, you can do so by mail to: Human Resources Administration Office of Constituent Services (OCS) 150 Greenwich Street, 35th Floor New York, NY 10007 You may also fax the forms to **212-331-4685**, email to ConstituentAffairs@dss.nyc.gov or give them to your worker.
➢ Please sign the HIPAA Authorization on **page 6** if you want your provider to send the forms to us. This will let us discuss information with your provider. Your provider should send us **pages 3 and 4** of this form. We will also accept signed documentation on the licensed provider's letterhead.
➢ You (or your provider) must provide us with any medical/clinical documents that support your request **within thirty (30) days**.
➢ You are responsible for returning documents to us (or making sure that your provider does) in support of this request.
➢ We will review all documentation provided to us and send you a written notice about our decision on your Reasonable Accommodation Request.
➢ If you do not agree with our decision, you or your authorized representative can file an appeal with the HRA ADA Compliance Officer. We will review your appeal to see if we made the right decision. To file an appeal, you have to ask us for an appeal in writing **within thirty (30) days** of the date we told you about the decision.

(Turn page)

NEED HELP GETTING DOCUMENTS?
➢ If you need help getting documents from your provider, please sign and return the HIPAA Authorization on **pages 5 and 6**.This will let us talk to your provider and get the documents we need.
➢ If your conditions make it hard for you to get medical/clinical documentation in support of your request, please call us at **212-331-4640** for help.

(Turn page)

Human Resources Administration
Department of Social Services

REQUEST FOR MEDICAL/CLINICAL INFORMATION

INSTRUCTIONS FOR PROVIDER

Your patient has requested that the New York City Human Resources Administration (HRA) provide him/her with a reasonable accommodation/modification in order to receive meaningful access to HRA's programs, benefits and services. Please provide a detailed description of the specific physical and/or mental condition(s) that affects the patient's ability to perform certain tasks and engage in certain activities, any reasonable accommodation needed and the relationship between the accommodation and the patient's disability or condition. You may attach additional medical information to the forms as needed.

Please fax this completed form to 212-331-4685 or return this to the patient.

Name of Patient (Please Print): _____

Date of Birth: _____

Social Security Number, if known: _____

Case Number, if known: _____

Name of Provider: _____

Address of Provider: _____

_____

Telephone Number of Medical Provider: _____

1) Please state patient's medical and/or mental health condition(s):

2) Please provide a detailed description of the specific physical and/or mental health restrictions/limitations affecting the patient's ability to perform certain tasks and engage in certain activities. Please describe how this affects the patient's ability to travel and participate in HRA appointments.

(Turn page)

REQUEST FOR MEDICAL/CLINICAL INFORMATION (Continued)

3) Indicate whether the patient's condition(s) is permanent, chronic or temporary. If the patient's condition(s) is temporary, please state its anticipated duration.

4) Indicate what treatment if any the patient is currently receiving associated with his/her medical and/or mental health conditions(s) including, but not limited to, any medication or therapy.

5) Please describe the reasonable accommodation needed by the patient and how the accommodation will assist the patient with their medical and/or mental health conditions.

6) Does the patient's physical and/or mental health condition(s) make it difficult for the patient to perform the following activities? (If so, please fully describe the difficulties the patient has for each checked box):

- ☐ Walking and/or Climbing Stairs: Describe: _____
- ☐ Traveling and/or Taking Public Transportation: Describe: _____
- ☐ Cognitive Functions (i.e. concentrating, remembering, understanding). Describe: _____
- ☐ Sitting or Standing for extended periods of time. Describe: _____
- ☐ Being in crowded places. Describe: _____

Licensed Provider's Signature **Date**

Licensed Provider's Number

(Turn page)

Human Resources Administration
Department of Social Services

HIPAA AUTHORIZATION FOR THE DISCLOSURE OF INDIVIDUAL HEALTH INFORMATION

Patient Name: **Social Security Number:**

Patient Address: **Date of Birth:**

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form. In accordance with Article 27-F of the New York State Public Health Law, the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), and 42 U.S.C. § 290dd-2 and its implementing regulations at 42 C.F.R. Part 2, I understand that:

1. This authorization may include disclosure of information relating to **ALCOHOL** and **DRUG ABUSE, MENTAL HEALTH TREATMENT**, except psychotherapy notes, and **CONFIDENTIAL HIV* RELATED INFORMATION** only if I place my initials on the appropriate line in Item 10(b). In the event the health information described below includes any of these types of information, and I initial the line on the box in Item 10(b), I specifically authorize release of such information indicated in Item 10(b) to the NYC Human Resources Administration (HRA).

2. In the event that HRA determines that I am potentially eligible for federal disability benefits, I authorize HRA to release my medical and/or mental health treatment information, which may include confidential HIV related information and/or alcohol or drug treatment records to the Social Security Administration (SSA) for its review of my eligibility for federal disability benefits.

3. I understand that I have the right to request a list of people who may receive or use my HIV related information without authorization. If I experience discrimination because of the release or disclosure 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 of Human Rights at **212-306-7450**. These agencies are responsible for protecting my rights.

4. I understand that signing this authorization is voluntary. My treatment, payment to treatment providers, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure. However, if I do not authorize HRA to share my medical information with SSA, this may result in a discontinuance of my Cash Assistance (CA) benefits.

*** Human Immunodeficiency Virus causes AIDS. The New York State Public Health Law protects information which reasonably could identify someone as having HIV symptoms, infection, or AIDS, or that reasonably could identify someone who may have been exposed to HIV or AIDS through contact with a protected individual.**

(Turn page)

5. I understand that I may revoke this authorization except to the extent that HRA and my medical provider have already acted upon it.

   I may revoke this authorization at any time by writing to the health care provider at the address specified below and to HRA at:

   NYC Human Resources Administration, Office of Constituent Services, 150 Greenwich Street, 35th Floor, New York, NY 10007

6. Authorized recipients of my medical information may, in certain instances, have the right to redisclose my medical documentation without the need to obtain additional written consent from me. I understand that such redisclosures may no longer be protected by federal or state law.

7. **This authorization does not authorize my medical provider to discuss my health information or medical case with anyone other than the NYC Human Resources Administration as specified in item 10(b).**

AUTHORIZATION TO DISCUSS HEALTH INFORMATION

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

   _____

   _____

9. Name and address of agency to whom this information will be sent:
   NYC Human Resources Administration, Customized Assistance Services, Office of Reasonable Accommodations, 150 Greenwich Street, 30th floor, New York, NY 10007.

10(a). Specific 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

10(b). By initialing here _____ (initials), I authorize _____ (Name of individual health care provider) to discuss my health information with the **NYC Human Resources Administration.**

11. Reason for release of information: **At request of patient**

12. Date or event on which this authorization will expire: **One year from that date of signature**

13. If not the patient, name of person signing form:

    _____

14. Authority to sign on behalf of patient:

    _____

All items on this form have been completed and my questions about this form have been answered. In addition, I have been provided with a copy of the form.

_____ _____

Signature of Patient or Authorized Representative by Law Date