Reset

NEW YORK CITY HOUSING AUTHORITY

Medical Verification Form

A. Case #:

B. You, the head of household, have indicated that a reasonable accommodation is required because of mental, developmental or emotional disability.

C. SECTION A: AUTHORIZATION FOR THE RELEASE OF MEDICAL INFORMATION

1. Name of the household member for whom the accommodation is requested:

a. *Last Name* **b.** *First Name* **c.** *MI*

2. Last 4 digits of Social Security Number

3. Date of Birth *(mm/dd/yyyy)*

D. AUTHORIZATION TO RELEASE INFORMATION

I, the above named Tenant, authorize the health care provider listed below to provide NYCHA with the following information about the person with a disability named above, as it relates to the disabled person's reasonable accommodation request.

- Information regarding the patient's need for the reasonable accommodation listed above, or a recommendation for an alternative reasonable accommodation

A translation of this document is available in your management office.
La traducción de este documento está disponible en la Oficina de Administración de su residencial.
Перевод этого документа находится в Вашем домоуправлении.
所居公房管理處備有文件譯本可供索取。
所居公房管理处备有文件译本可供索取。

The English language version of this document is the official, legal, controlling document.
Any translated version of this document is not an official document.

The Health Care Provider is authorized to release information to NYCHA at the office and address listed below. The tenant/applicant authorizes release of this information, even though it may otherwise be confidential under New York State Law or the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

- This Authorization does not waive any professional relationship confidentiality.
- This Authorization can be revoked by me at any time, by written statement to the Health Care Provider.
- The information provided to NYCHA will be in response to this form, and can either be written and attached to this form or provided as additional documents or responses to follow-up inquiries from NYCHA.
- This Authorization is for the limited time and purpose of allowing NYCHA to consider and respond to my reasonable accommodation request. In any event, this authorization expires one year from the date signed.

E. I hereby authorize you to provide the New York City Housing Authority with a description of the need for a reasonable accommodation.

F. This release shall not constitute a waiver of the confidentiality of our professional relationship.

1. Signature of Family Member with Disability

2. Date

(mm/dd/yyyy)

3. Signature of Parent or Guardian *(if applicable)*

4. Date

(mm/dd/yyyy)

G. SECTION B: HEALTH CARE PROVIDER/SOCIAL WORKER RESPONSE

Please have the health care provider or social worker complete this section for the household member listed on page 1 for whom you are requesting an accommodation.

1. SOCIAL WORKER/HEALTH CARE PROVIDER INFORMATION ☐ **a.** Health Care Provider ☐ **b.** Social Worker

2. Name of Social Worker/Health Care Provider

a. *Last Name* **b.** *First Name* **c.** *MI*

d. Your Agency Affiliation

e. Agency's Address

f. Office Phone – **g.** Professional License #

3. PATIENT/CLIENT INFORMATION:

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

b. When did you last evaluate this patient/client? *(mm/dd/yyyy)*

c. Does your patient/client have a physical, medical, mental or psychological impairment or history of record of such impairment that requires accommodation? ☐ **1.** Yes ☐ **2.** No

d. If applicable: please explain which major life activities may be affected.

4. BRIEF DESCRIPTION OF CONDITION AND REQUIRED ACCOMMODATION:

Describe, without disclosing the disability, how the accommodation would suit the impairment in the space provided below. If you would like to provide additional information, please attach it to this form.

a. Is this impairment temporary? ☐ **1.** Yes ☐ **2.** No ☐ **3.** Unable to make determination

b. If *'yes'*, how is the accommodation linked to the person's impairment? (Note: in order for an accommodation to be considered, a connection must be made between the impairment and the requested accommodation. You do not have to disclose the full diagnosis or exact impairment). If necessary, attach additional information to this form.

5. If the impairment is temporary or if you are not sure of how long your client/patient will be impaired, please explain why in the space provided below. If you would like to provide additional information, please attach it to this form.

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

a. *Signature of Health Care Provider/Social Worker*

b. DATE ☐☐☐☐☐☐☐☐ *(mm/dd/yyyy)*

c. Health Care Provider: Place medical stamp below.