Reset

NEW YORK CITY HOUSING AUTHORITY

Medical Verification Form

A. Case #:

B. In order for the New York City Housing Authority ("NYCHA") to evaluate your request for a reasonable accommodation because of mental, developmental or emotional disability, NYCHA requires information about your disability from a licensed health care provider or social worker. This health care provider or social worker should be familiar with the history of your disability. Please complete sections C-F of this form. The health care provider or social worker must complete section G and H (if requesting an assistance animal). This form should be completed and signed by the disabled individual or authorized representative.

If the reasonable accommodation request is for a disabled individual who is under 18 years old or is unable to sign, the parent, guardian or authorized representative must complete and sign this form on behalf of the disabled individual.

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

1. Name of the individual 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 individual or my authorized representative, authorize the health care provider or social worker identified below to provide NYCHA with the following information about my disability , as it relates to my reasonable accommodation request.

- Information regarding my need for the reasonable accommodation listed above, or a recommendation for an alternative reasonable accommodation.

The health care provider or social worker is authorized to release information to NYCHA at the office and address listed below. The above-named individual or authorized representative, authorizes the 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 between me and the health care provider or social worker identified below.
- This Authorization can be revoked by me at any time, by written statement to the health care provider or social worker.
- The health care provider or social worker completing this form may include additional documents in support of the reasonable accommodation request or in response to any NYCHA follow-up inquiries.
- 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, as my health care provider or social worker, to provide NYCHA with the information requested in section G and H (if requesting an assistance animal).

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

1. Signature of Individual with Disability

2. Date

(mm/dd/yyyy)

3. Signature of Parent, Guardian or Authorized Representative *(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 individual identified 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, true and complete 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.

H. FOR ASSISTANCE ANIMALS ONLY

PLEASE COMPLETE THIS SECTION IF THE REASONABLE ACCOMMODATION BEING REQUESTED IS FOR AN ASSISTANCE ANIMAL.

There are two types of assistance animals: (1) service animal is any dog that is individually trained to do work or perform tasks for the benefit of an individual with a disability, including a physical, sensory, psychiatric, intellectual, or other mental disability. The work or tasks performed by a service animal must be directly related to the individual's disability; and (2) other (trained or untrained) animals that do work, perform tasks, provide assistance, and/or provide therapeutic emotional support for individuals with disabilities, commonly referred to as “support animals.”

Please complete the following sections, sign in the space indicated above and return it to your patient.

1. Please indicate the nature of your relationship with the patient.

2. Please discuss the patient’s physical or mental impairment or disability for which the reasonable accommodation request is being sought.

3. Please describe how the work, assistance, task performed or therapeutic emotional support provided by the animal benefits the patient because of their disability or impairment discussed above.

H. FOR ASSISTANCE ANIMALS ONLY

If the animal being requested as a reasonable accommodation is a unique animal *(i.e. an animal traditionally not kept in the household as a domesticated animal*), please complete the following additional questions:

4. Please identify the date of the last consultation with the patient. | | | | | | | | | |
(mm/dd/yyyy)

5. Please provide any information you possess about the specific animal being requested by the patient or whether the animal was specifically recommended by you to serve as an assistance animal for the patient.

6. Please identify the unique circumstances justifying the patient's need for the particular animal.

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客戶服務中心備有文件的翻譯和大號字體版本可供索取。 NYCHA所提供的文件譯本僅供參考。請填寫文件的英文版本。
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