Reset

NEW YORK CITY HOUSING AUTHORITY
APPLICATIONS AND TENANCY ADMINISTRATION DEPARTMENT

A. Case #

B. **Re: MOBILITY IMPAIRMENT ACCOMMODATION VERIFICATION**

C. Dear Applicant:

You have indicated that you or a member of your household needs a fully accessible apartment in connection with your housing because of a mobility impairment. A health care provider must verify this information.

Please bring this letter to your doctor or other health care provider.

The New York City Housing Authority will use this information only for the purpose of offering you an accessible apartment, and will keep it confidential pursuant to law. If you choose not to authorize the release of this information, we will no longer consider your request for a fully accessible apartment.

D. AUTHORIZATION TO RELEASE INFORMATION

Last | First | MI

E. **RE:** Family member with mobility impairment:

F. I hereby authorize the release of information to the New York City Housing Authority regarding the disability conditions described on this form. This release shall constitute a waiver of the confidentiality of our relationship, if any.

G. *Date*

H. *Affected Family Member/Parent/Legal Guardian*

I. *Relationship to Applicant*

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Case #

Clients Name:

HEALTH CARE PROVIDER / SOCIAL WORKER RESPONSE FORM

We would appreciate your cooperation in furnishing the requested information regarding the individual named in the authorization on this form. Please mail the completed form directly to us at the address indicated above.

Your Name

(Last name) *(First name)* *(Title)*

Your Agency Affiliation

Agency's Address

Office Phone # ( ) –

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

2. When did you last evaluate this patient/client?

3. Your patient/client has told us (s)he needs an accessible apartment because of a mobility impairment.

Is this true? Yes No

Please explain:

4. Is the mobility impairment temporary? ☐ Yes ☐ No

Please explain:

Date
(mm/dd/yyyy)

Signature of Health Care Provider/Social Worker