Reset

NEW YORK CITY HOUSING AUTHORITY
APPLICATIONS AND TENANCY ADMINISTRATION DEPARTMENT

A. Case #

B. RE: REASONABLE ACCOMMODATION LETTER

C. Dear Applicant/Tenant:

You have indicated that a family member requires an accommodation because of a health condition. We need to verify this information with either a health care provider or social worker.

This information is not used in determining whether you are eligible for an apartment. It is only used to determine whether you are entitled to the requested accommodation.

The family member with the health condition (or his/her parent or legal guardian) should review the back of this form and sign the authorization below. Then please give this form to your health care provider or social worker.

D. AUTHORIZATION TO RELEASE INFORMATION

1. TO: _____

2. *Name of Social Worker or Health Care Provider*

3. RE:

4. *Name of Client/Patient*

5. I hereby authorize you to provide the New York City Housing Authority with the information requested on the back of this form about the following health condition:

_____

_____

_____

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

7. Date

8. Signature of Client/Patient or Parent/Legal Guardian

9. Relationship to Applicant

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.

Case #

Client Name:

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 accommodation because of health conditions indicated on the authorization form.

   Is this true? Yes No Don't know

Please explain why your patient/client's health condition requires an accommodation. (i.e., inability to share a bedroom due to large medical equipment such as a hospital bed or a lower floor for a person with acrophobia, etc.)
If your patient/client is disabled and requires a permanent transfer in order to be closer to you as a health care provider or the facility at which you practice, include the frequency of the visits of the patient/client, the length of time you anticipate visits at this frequency continuing, and the specific reason the transfer is required.

4. Is medical condition temporary? ☐ Yes ☐ No ☐ Don't Know

Please explain:

Date

Signature of Health Care Provider / Social Worker