# REASONABLE ACCOMMODATION REQUEST (RAR) FORM

If you have a disability and need help to take part in HRO programs and services, or require accommodations with respect to the repair or rebuilding of your home, you may request such accommodations from HRO. Some examples of reasonable accommodations are scheduling appointments to avoid rush hour travel, assistance reading forms and notices, and conducting business by telephone, fax or mail, if appropriate. Moreover, in the event that you are eligible for home rebuilding or repair through HRO's Build it Back program, you, or a resident in your building, may require accommodation standards for the mobility impaired in construction. HRO provides reasonable accommodations to individuals with disabilities to ensure that such individuals receive meaningful access to HRO's programs, benefits and services, and to ensure that the repair and reconstruction work conducted by HRO meets the specific needs of the individuals residing in the home.

| **INSTRUCTIONS AND INFORMATION** |
|---|
| ➢ To assist HRO in making a determination on your request for a reasonable accommodation, please complete and submit **pages 2, 3 and 4** of this form to:<br>**Mayor's Office of Housing Recovery Operations**<br>**Church St Station**<br>**P.O. Box 468**<br>**New York, NY 10008-0468**<br>➢ You may also fax the forms to **(212) 312-0857** or e-mail them to **legal@recovery.nyc.gov** |
| ➢ You must submit any medical documentation supporting your request with this form or within<br>➢ **twenty** (**20) days** of this request. |
| ➢ Please ask your medical provider to complete and sign the Request for Medical Information Form (enclosed) or appropriate signed medical documentation on the medical provider's letterhead and return the form/documentation to you. |
| ➢ You are responsible for returning your medical documentation to HRO in support of this request. |
| ➢ If your medical or mental health conditions make it difficult for you to complete this form you may contact HRO at **(212) 615-8017** for assistance. |
| ➢ If your medical or mental health conditions make it difficult for you to gather medical documentation in support of your request, you may contact HRO at **(212) 615-8017** or e-mail HRO at **legal@recovery.nyc.gov** for assistance. Please complete the enclosed HIPAA Authorization for the Disclosure of Individual Health Information (NYS OCA Form No. 960) form and send it to:<br>**Mayor's Office of Housing Recovery Operations**<br>**Church St Station**<br>**P.O. Box 468**<br>**New York, NY 10008-0468** |
| ➢ HRO will mail you a letter to acknowledge receipt of your Reasonable Accommodation Request. |
| ➢ HRO will review all documentation provided by you and your medical provider and send you a written notice regarding our determination on your Reasonable Accommodation Request. |

# REASONABLE ACCOMMODATION REQUEST (RAR) FORM

**Name** (Please Print): _____

**Telephone Number**: _____

**Mailing Address**: _____

_____

1) Do you receive Home Care Services or have a Home Attendant? ☐ Yes ☐ No

If you have answered "yes" to question 1, please indicate the number of hours you receive per day, the number of days per week for which you receive services and the reason(s) you receive home care services.

2) Describe your medical or mental health condition, the reasonable accommodation you are requesting and why the accommodation is necessary. (Attach additional sheets, if needed, and any medical information you choose to provide in support of your requested accommodation.)

3) If your request is for a reasonable accommodation during the application intake and review phases of HRO's programs, are you also requesting the use of accessible construction standards (for the mobility-impaired) during the construction phase, if you are eligible for and elect to receive repair or reconstruction services from the programs?

☐ Yes ☐ No

4) If you responded "yes" to question 3, please describe the construction-related accommodations you would require.

**Signature:** _____ **Date:** _____

**Print Name:** _____

**Authorized Representative's Signature:** _____ **Date:** _____

**Print Name:** _____

# REQUEST FOR MEDICAL INFORMATION FORM

| INSTRUCTIONS FOR MEDICAL PROVIDER |
| --- |
| Your patient has requested that the NYC Mayor's Office of Housing Recovery Operations (HRO) provide him/her with a reasonable accommodation/modification in order to receive meaningful access to HRO'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/modification needed and the relationship between the accommodation/modification and the patient's impairment. You may attach additional medical information to the forms as needed.<br><br>**Please return this completed form to the patient.** |

**Name of Patient** (Please Print): _____ **Date of Birth**: _____

**Name of Medical Provider**: _____

**Address of Medical 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 the impairment affects the patient's daily functioning.

## **REQUEST FOR MEDICAL INFORMATION FORM** (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/modification needed by the patient, if any, ***during the process of applying for benefits from the City*** and the relationship between it and client's medical and/or mental health conditions.

6) Please describe the reasonable accommodation/modification needed by the patient, if any, with respect to ***home construction or repair of the patient's home (e.g. access for the mobility impaired)*** and the relationship between it and client's medical and/or mental health conditions.

7) 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: _____

_____

**Medical Provider's Signature: _____ Date: _____**

**Medical Provider's License number: _____**

OCA Official Form No.: 960

# AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA

**[This form has been approved by the New York State Department of Health]**

| Patient Name | Date of Birth | Social Security Number |
|---|---|---|
| Patient Address | | |

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 New York State Law and the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 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 9(a). 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 9(a), I specifically authorize release of such information to the person(s) indicated in Item 8.
2. If I am authorizing the release of HIV-related, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from redisclosing such information without my authorization unless permitted to do so under federal or state law. 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) 480-2493 or the New York City Commission of Human Rights at (212) 306-7450. These agencies are responsible for protecting my rights.
3. I have the right to revoke this authorization at any time by writing to the health care provider listed below. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.
4. I understand that signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.
5. Information disclosed under this authorization might be redisclosed by the recipient (except as noted above in Item 2), and this redisclosure may no longer be protected by federal or state law.
6. **THIS AUTHORIZATION DOES NOT AUTHORIZE YOU TO DISCUSS MY HEALTH INFORMATION OR MEDICAL CARE WITH ANYONE OTHER THAN THE ATTORNEY OR GOVERNMENTAL AGENCY SPECIFIED IN ITEM 9 (b).**

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

8. Name and address of person(s) or category of person to whom this information will be sent:
**NYC Mayor's Office of Housing Recovery Operations, Church St Station, P.O. Box 468, New York, NY 10008**

9(a). Specific information to be released:

- ❑ Medical Record from (insert date) _____ to (insert date) _____
- ❑ Entire Medical Record, including patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, consults, billing records, insurance records, and records sent to you by other health care providers.
- ❑ Other: _____
  _____

Include: (*Indicate by Initialing*)

_____ **Alcohol/Drug Treatment**
_____ **Mental Health Information**
_____ **HIV-Related Information**

**Authorization to Discuss Health Information**

(b) ❑ By initialing here _____ I authorize _____
Initials — Name of individual health care provider

to discuss my health information with my attorney, or a governmental agency, listed here:

_____
(Attorney/Firm Name or Governmental Agency Name)

| 10. Reason for release of information:<br>❑ At request of individual<br>❑ Other: | 11. Date or event on which this authorization will expire: |
|---|---|
| 12. If not the patient, name of person signing form: | 13. 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 a copy of the form.

_____ Date: _____
Signature of patient or representative authorized by law.

*** Human Immunodeficiency Virus that causes AIDS. The New York State Public Health Law protects information which reasonably could identify someone as having HIV symptoms or infection and information regarding a person's contacts.**