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Department of Social Services

FAMILY INDEPENDENCE ADMINISTRATION

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POLICY BULLETIN #14-29-OPE

(This Policy Bulletin replaces PB #13-85-OPE)

REVISED TEMPORARY HOME VISIT NEEDED/HOMEBOUND (HVN/HB) STATUS REQUEST PROCESS

Date:	**Subtopic(s):**
March 7, 2014	HVN, HB, Forms, Codes

Revisions to the Original Policy Bulletin:

This policy bulletin is being revised to inform staff of the following:

- The Home Visit Needed/Homebound(HVN/HB) liaisons have been granted access to post Action Code **192P** in NYCWAY **only** when it cannot be entered through the Paperless Office System (POS).
- Action Code **192P** **should not** be posted into NYCWAY if there is an open **192A**, **192F**, **192L** or **192U** on the case.
- The Notice of Removal of Home Visit Needed/Homebound Status (**FIA-1028e**) has been revised to remove the selection "Your new medical documentation no longer supports HVN/HB status" and the box with the "Americans with Disabilities Act (ADA) Appeal Process" information.
- The Missed Homebound Assessment Interview (**FIA-1028n**) form has been revised to include the date of the missed appointment and a "Failure to contact us may result in a denial of your Home Visit Needed/Homebound status request" statement.
- The Notification of Expiration of Home Visit Needed/Homebound Status (**FIA-1028k**) form has been revised to remove the telephone number and address from the form and allow space for variable text. MIS will provide the most current information for telephone and address.
- **Attachment A** has been updated to include the new language on the **FIA-1028n** under the Purpose/Instruction section.
- **Attachment B** has been updated to include Action Code **19TA**.

Purpose:

The purpose of this policy bulletin is to inform Job Center and Non Cash Assistance Supplemental Nutrition Assistance Program (NCA SNAP) Center staff that the temporary process for applicants/participants who request HVN/HB status has been revised. The temporary process must be used until the HVN/HB policy directive is published.

Family Independence Administration (FIA) staff conduct initial home visits as an accommodation to applicants/participants who claim to have a physical or mental health impairment that restricts the individual's ability to leave his/her place of residence or neighborhood, or are otherwise unable to appear at an FIA Center.

HVN/HB status requests are not limited to application and recertification appointments and may be requested at any time that an applicant/participant is unable to appear in-person to conduct agency-related business where no other accommodation is reasonably viable (such as mail, fax, phone or authorized representative, etc) to meet the individual's needs.

Cash Assistance (CA) Requests for Home Visits

A CA applicant/participant may request a home visit at any time via telephone, fax or mail. FIA staff must keep a record of all HVN/HB requests on the Control of Assignments/Referrals (Form **W-708**), assign and schedule a home interview for all applicants/participants who request a home visit. FIA staff must honor initial HVN/HB requests without requiring documentation before the home visit is conducted.

New Information

For participants requesting a home visit, Action Code **192P** (HVN/HB Status Request Pending Documentation) must be posted on the day of the HVN/HB request, *before* the home visit is conducted to avoid potential adverse actions until the HVN/HB status request is processed. The case cannot be transferred to another center while there is an open **192P** in NYCWAY. The HVN/HB Liaisons will be able to post Action Code **192P** directly in NYCWAY only when staff is unable to post the code through POS. Staff should not post a new **192P** if there is an open **192A**, **192F**, **192L** or a **192U** on the case.

FIA staff must contact the applicant/participant before scheduling a home visit to ensure that the individual will be available. The designated JOS/Worker will select the first option on the Notice of Scheduled Home Visit Form (**FIA-1028h**) confirming the home visit appointment that was agreed to during the telephone conversation, complete the form and send it to the applicant/participant.

If FIA staff is not able to contact the applicant/participant to schedule a home visit, the designated JOS/Worker will select the second option on the **FIA-1028h** requesting that they contact the Center. The designated JOS/Worker must complete the form and mail it to the applicant/participant.

In both of the instances mentioned, on the **FIA-1028h** in "*The purpose of this home visit is to discuss*:" box, the designated JOS/Worker must indicate the reason for the visit (application, recertification, etc.) and in the "*You must have the following documentation available during the home visit*:" box, the designated JOS/Worker must indicate the documents required.

Application received

Refer to **PD #11-12-OPE** for further information about ESNAP eligibility

If the CA application has been received before the home visit, the case must be screened for Expedited Supplemental Nutrition Assistance Program (ESNAP) Service and the Home Visit Appointment Notice (**FIA-1028b**) must be sent indicating the appropriate date.

If the applicant is eligible for ESNAP service, the home visit must be conducted within two (2) business days from receipt of the application.

If the applicant is not eligible for ESNAP service, the home visit must be conducted within three (3) business days of receipt of the application.

The Eligibility Factors and Suggested Documentation Guide (**W-119D**) with the applicable eligibility factors checked must be sent to the applicant with the **FIA-1028b**.

If the applicant called for a home visit and no application was received, an application package must be taken to the home within three (3) business days from the request.

HVN/HB forms

In addition to the application/recertification packet, the HVN/HB request process for all ongoing CA cases requires the designated JOS/Worker to take the following forms to the home visit:

- Home Visit Needed/Homebound Determination Process Form (**FIA-1028**), which explains the HVN/HB status request process.
- Two (2) copies of the HIPAA Authorization for the Disclosure of Individual Health Information Form (**HRA-108**) that must be completed and signed by the applicant/participant. One copy of the form must be brought back to the Job Center and one copy is for the applicant/participant to give to his/her medical provider.

  Note: If the applicant/participant refuses to sign the **HRA-108**, the designated JOS/Worker must explain to the individual that he/she must assume full responsibility to ensure that complete medical documentation is returned to FIA and that without the signed release, HRA cannot provide help in securing medical documentation on his/her behalf.

- The Home Visit Needed Request Activities of Daily Living – Client Information Form (**CAS-102**) to be completed at the home visit with the applicant/participant, signed and returned to the Job Center;
- The Home Visit Needed Request Clinician Assessment Form (**CAS-103**), along with a postage paid return envelope for the applicant's/participant's medical provider to return to the Job Center within 20 calendar days.

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  Note: If an individual indicates on the **CAS-102** that he/she has submitted a supportive housing application (**HRA 2010e**) within the past twelve months or has completed a WeCARE medical assessment within the past twelve months, these documents should be submitted to CAS even if the **CAS-103** is not submitted within the 20 calendar day timeframe.

- Two (2) copies of Documentation Request for HVN/HB Status Form (**FIA-1028i**). One copy must be scanned and indexed into the case record.

All relevant HVN/HB forms and action codes can be accessed on Filenet or by clicking the hyperlinks embedded in **Attachment A** and **Attachment B**.

Home visit requests for One-Shot Emergency Assistance cases will not be processed in the same manner as requests for on-going CA cases. For home visit requests from One-Shot Emergency Assistance applicants, the designated JOS/Worker must make a home visit and bring the application packet to the home; however One Shot Emergency Assistance cases are not required to complete HVN forms or return HVN/HB medical documents.

For these cases, the designated JOS/Worker must enter "Yes" to the homebound question "*Is any adult in the household homebound or requesting a home visit?*" on the POS Medical screen. Action Code **19SI** (HVN/HB Single Issue One Shot Deal Request Pending Documentation) will autopost in NYCWAY for identification purposes only and will self-complete.

Note: If the JOS/Worker designated to conduct the home visit fails to appear for the home visit, the appointment will be rescheduled. However, if the JOS/Worker arrives after the appointment time and the applicant/participant still wishes to conduct the interview, the JOS/Worker must conduct the home visit interview. If the JOS/Worker arrives after the appointment time and the applicant/participant does not wish to conduct the interview, the appointment should be rescheduled.

If the applicant/participant is not home at the time of the scheduled home visit appointment, upon return to the Job Center, the designated JOS/Worker must mail the Missed Homebound Assessment Interview Form (**FIA-1028n**) to the applicant/participant. The applicant/participant must contact HRA to reschedule the appointment and to verify that he/she still wants to pursue the request for HVN/HB status and/or the application.

Offer of a WeCARE Referral

Work rules required-applicants/participants ages 18-59 who do not qualify for another work exemption.

If an otherwise work rules required CA applicant/participant requests HVN/HB status but cannot gather his/her own medical documentation and does not want assistance in obtaining documentation, the JOS/Worker should offer a WeCARE referral. The purpose of the referral is for WeCARE to assess the applicant's/participant's functional capacity and determine if home visits are needed. WeCARE appointments for HVN/HB assessments are not mandatory.

Refer to **PD #13-31-ELI** for information on WeCARE.

If the WeCARE referral is accepted, a HVN/HB request is made to CAS using the process on page 8; however, the JOS/Worker must still complete the **HRA-108** and **CAS-102** with the individual and provide the **CAS-103**. The applicant's/participant's name should be entered in the forms using the last name, first name format.

WeCARE assessment appointments are generally available up to 17 days from the date of the initial request for an assessment appointment.

In addition, the JOS/Worker must advise the applicant/participant that he/she will be sent a Medical Provider Appointment Wellness, Comprehensive Assessment, Rehabilitation and Employment (WeCARE) Referral for Assessment (**CAS-300**) form, which will have the date, time and location of the WeCARE assessment appointment.

Requests for Assistance to Obtain Medical Documents

If the applicant/participant declines a WeCARE referral or is non work rules required and has his/her own medical provider but states that he/she needs assistance in obtaining medical documentation, the JOS/Worker must offer the Human Resource Administration's (HRA's) assistance in obtaining medical documentation. Individuals who accept HRA's offer will be provided assistance by CAS. The **HRA-108** must be completed and signed in order for CAS to provide assistance.

Return to the Job Center

When the designated JOS/Worker returns to the Job Center after conducting the home visit interview, he/she must:

- Scan and index the **HRA-108** and **CAS-102** into the OneViewer;
- take any actions necessary in POS, including registering new applications;
- enter "**Y**" to the homebound question "*Is any adult in the household homebound or requesting a home visit?*" on the POS Medical screen (if not previously recorded) and choose the individual requesting HVN/HB status from the drop-down menu.

All NYCWAY action codes associated with the HVN/HB process are listed on **Attachment B**.

AFIS Homebound Indicator

AFIS is a requirement only for CA benefits.

Once the POS HVN/HB question is answered, POS enters "**6**" (Exempted Homebound Individual) on the POS TAD in the Automated Finger Imaging System (AFIS) exemption field for all HVN/HB individuals who do not already have an AFIS code indicating that the individual has been finger imaged. This code will exempt the individual from the finger imaging requirement.

See the instructions on page four (4) for processing One-Shot Emergency

Additionally, once the POS HVN/HB question is answered, Action Code **192P** (HVN/HB Status Request Pending Documentation) will autopost in NYCWAY for ongoing CA cases to exempt the applicant from in-center appointments until the outcome of the HVN/HB status request is determined and/or the resolution of any appeal is complete.

Note: For <u>participants</u> requesting a home visit, Action Code **192P** should be posted *before* the home visit is conducted to record the participant's request for HVN/HB status and to prevent call-in appointments until the outcome of the HVN/HB status request is determined and/or the resolution of any appeal is complete.

See page five (5) for the WeCARE HVN process

- For work rules required applicants/participants who accepted a WeCARE referral, make the referral through POS. Action Code **99WC** (HVN WeCARE Referral Accepted – Applicants) or **19WC** (HVN WeCARE Referral Accepted – Participants) will post in NYCWAY.

  NYCWAY will post a batch referral to WeCARE appointment code **99WA** (HVN Referral to WeCARE – applicants)**/19WA** (HVN Referral to WeCARE – participants) and MIS will mail the batch appointment letter.

<u>WeCARE Appointment</u>

Rescheduled WeCARE appointment

Once the appointment notice is received by the applicant/participant, he/she may *reschedule* the appointment by contacting the WeCARE vendor. When the appointment is rescheduled, a new Action Code **99WA** (HVN Referral to WeCARE – applicant)/**19WA** (HVN Referral to WeCARE – participant) will be posted by the vendor.

Cancelled WeCARE appointment

If the applicant/participant subsequently contacts the WeCARE vendor to *cancel* the appointment, the vendor will notify Customized Assistance Services (CAS). WeCARE staff will enter Action Code **99WN** (Cancel WeCARE HVN Request - Applicant) or **19WN** (Cancel WeCARE HVN Request - Participant) in NYCWAY, which will generate the HVN WeCARE Assessment Cancellation Form (**CAS-311**). Form **CAS-311** will be mailed along with the **CAS-103**, instructing the applicant/ participant that he/she must still submit medical documentation for an HVN status determination within 20 days of the date of the letter.

Fails to attend WeCARE appointment

If an applicant/participant fails to attend or to reschedule the WeCARE appointment, the WeCARE vendor will provide outreach services. The vendor will post Action Code **19WO** (HVN-WeCARE Outreach) in NYCWAY. The **19WO** has a Future Action Date (FAD) which allows for the outreach to take place before further action is taken.

If outreach is successful and the individual attends the WeCARE appointment, the vendor posts Action Code **19WB** (HVN WeCARE Outreach Successful) and continues the HVN/HB assessment process.

If outreach is unsuccessful, Action Code **19WR** (HVN WeCARE Outreach Unsuccessful) autoposts when the **19WO** outreach FAD expires and places the case on the **HVRVI** worklist for review by the HVN/HB Liaison. If no other documents (or requests for assistance in obtaining documents) are received from the applicant/participant to support the HVN/HB claim, the HVN/HB Liaison must deny the HVN/HB status request by manually posting Action Code **19ND** (HVN Medical Documentation Not Returned) in NYCWAY.

The applicant/participant must be sent the Notification of Home Visit Needed/Homebound Status Determination Form (**FIA-1028a**), along with the Request for an Appeal of a Reasonable Accommodation Determination Form (**HRA-102**) that provides instructions for filing an appeal of the denial.

<u>Request of Additional Time to Submit Documentation</u>

If the applicant/participant requests additional time to submit documentation and the request is approved, the JOS/Worker will enter Action Code **19TR** (Additional Time Required For Document) with a Future Action Date in NYCWAY.

Director's Designee/HVN/HB Liaison

The Director's Designee/HVN/HB Liaison must oversee all home visit requests. He/she is responsible for ensuring that the collected HVN/HB documents are in the viewer before emailing a request for a status determination to CAS/Office of Reasonable Accommodations (ORA).

The Home Visit Needed (HVN)/Homebound (HB) Status Liaison Checklist of Documents for CAS Review (**FIA-1028L**), has been created as a reference for the HVN/HB Liaison when sending notification to CAS that documentation is available for their review.

Note: Completed packets must include either the **CAS-103** or other medical documentation on the medical provider's letterhead. The only exception is if the individual indicated on the **CAS-102** that they have submitted a supportive housing application (**HRA 2010e**) within the past twelve months or if they have completed a WeCARE medical assessment within the past twelve months. In these instances, a **CAS-103** or other medical documentation is not required.

The Director's Designee/HVN/HB Liaison must ensure that the following collected/returned documents are scanned, indexed and in the viewer:

Medical documentation returned

- a signed and completed **HRA-108** form. If the individual refused to sign **HRA-108,** write across the form "Refused to Sign", scan and index, and include it in the packet to CAS. Note: A completed **HRA-108** is only required when an individual is requesting HRA's assistance to obtain medical documentation.
- a signed and completed **CAS-102** form; and
- a signed and completed **CAS-103** form **or** other appropriate signed medical documentation on the medical provider's letterhead (unless the individual indicated on the **CAS-102** that they have submitted a supportive housing application [**HRA 2010e**] within the past twelve months or if they have completed a WeCARE medical assessment within the past twelve months.)

Note: For individuals who are reapplying for CA, ensure that both the Application Registration (App Reg) number and the case number (if available) are entered on the HVN/HB forms and that the case name entered on the forms is in the last name, first name format.

After confirming that all of the required documents are completed and in the viewer, the Director's Designee/HVN/HB Liaison must:

- notify CAS/ORA via email about the request for an HVN/HB status determination. The email must be sent to the CAS ADA mailbox. The subject line should read HVN/HB Request Documents (Center #). The body of the email should list all the documents that have been scanned into the OneViewer and include the completed **FIA-1028L** as an attachment;
- enter Action Code **19DC** (Complete Document Packet Sent to CAS) in NYCWAY to indicate that the email was sent to CAS informing them of the availability of the information to be reviewed.

Request for assistance to gather medical documentation

For applicants/participants who requested help obtaining medical documentation, the Director's Designee/HVN/HB Liaison must:

- enter Action Code**19DO** (CAS help requested) in NYCWAY;
- send an email and the scanned completed copy of Form **HRA-108** to CAS at the CAS ADA mailbox.

The subject line of the email should read, "HVN/HB Request for Assistance with Medical Documentation".

No documentation and no medical provider

For applicants/participants who have no medical documentation, no medical provider, are not work rules required, or are unable to attend a WeCARE referral, the Director's Designee/HVN/HB Liaison must contact the Regional Manager. The Regional Manager will contact CAS/ORA who will request that a New York County Health Services Review Organization (NYCHSRO) doctor make a home visit.

Failure to Return Medical Documentation

CA and NCA SNAP applications cannot be denied for failure to return medical documentation for HVN/HB status.

For applicants/participants who do not return medical documents, the designated Worker will enter Action Code **19ND** (HVN Medical Documents not Returned) in NYCWAY. NYCWAY will generate the **FIA-1028a** indicating that the HVN/HB status is denied because no medical documentation was submitted and the **HRA-102** Request for an Appeal of a Reasonable Accommodation Determination.

Medical documentation is not necessary for CAS review for applicants/participants who indicate on the **CAS-102** that they have submitted a supportive housing application (**HRA 2010e**) within the past twelve months or they have completed a WeCARE medical assessment within the past twelve months. In these instances, the Director's Designee/HVN/HB Liaison must enter code(s) **19PW** (WeCARE Assessment in Past 12 Months) and/or **19PH** (Supportive Housing Application (**HRA 2010e**) Submitted within Past 12 Months) if documentation is not received after 20 days. The liaison should then submit the packet to CAS without medical documentation.

Under no circumstance should a case be rejected for CA or SNAP because of failure to submit either medical documentation or the CAS forms as a result of an HVN/HB request. Failure to submit medical documentation/CAS forms does not affect the individual's eligibility for CA or SNAP, only the individual's eligibility for HVN/HB status.

CAS Office of Reasonable Accommodation Review

As part of the HVN/HB medical review process, HRA's Customized Assistance Services' (CAS) Office of Reasonable Accommodation (ORA) must review all supporting medical documentation submitted and make a clinical determination of the individual's eligibility for HVN/HB status.

If no medical documentation is submitted with the request and no medical documentation is found in the CAS database or WeCARE Viewer, CAS will deny the HVN/HB request.

CA Applicant/Participant Requests to Withdraw HVN/HB Status

If a CA applicant/participant contacts a Job Center to request removal of his/her HVN/HB status, the designated Worker/HVN/HB Liaison must:

- send or give the applicant/participant a Request to Remove Home Visit Needed/Homebound Status (**FIA-1028d**) to be completed, signed and returned;
- after receipt of the **FIA-1028d**, annotate the POS case record to indicate the request to withdraw HVN/HB status;
- scan and index the **FIA-1028d**; and
- contact the Regional Office.

The Regional Office Designee must:

- review and confirm the applicant/participants request for removal of HVN/HB status;
- notify the Deputy Commissioner's Office by forwarding a copy of the completed **FIA-1028d** to the "FIA ADA" mailbox. The subject line of the e-mail must read "Request to Withdraw HVN/HB Status for_____" (include the individuals name and case number in the subject box).

The Deputy Commissioner's Designee will process the withdrawal by:

Note: Job Center/Regional Staff should **not** remove an HVN/HB status code in NYCWAY

- posting Action Code **192W** (HVN/HB Status Request Withdrawn) in NYCWAY. NYCWAY will update POS in the overnight batch processing; and
- sending the applicant/participant a Notice of Removal of Home Visit Needed/Homebound Status Form (**FIA-1028e**).

HVN/HB Request Code Posted in Error

If the worker answered **"**Yes (**Y**)" to the POS question "*Is any adult in the household homebound or requesting a home visit?*" in error and the **192P** has posted in NYCWAY, the JOS/Worker must immediately notify the Designated Supervisor or Center Director who must send a request to the POS HelpDesk to change the answer in POS from **Y** to **N** and to the NYCWAY HelpLine to enter Action Code **19EE** (HVN/HB Administrative Removal). The **19EE** is a code that cannot be entered in NYCWAY by Job Center Staff.

Any questions about the new HVN/HB request determination process should be directed to the Job Center's Regional Manager.

Recertification Process for CA Participants in HVN/HB Status

Based on the **WIN32X**, if a CA recertification is required for a case that has an HVN/HB indicator in WMS, POS will autopost code **908H** (HVN/HB Recertification) in NYCWAY to prevent the scheduling of an in office recertification appointment and place the case into the new **Schedule Home Visit Recertification** queue for each Job Center.

Refer to **PB #12-101-OPE** for recertification kit information

The Director or Designee at each Job Center must access the **Schedule Home Visit Recertification** queue and assign the scheduling activities to the designated JOS/Workers. The designated JOS/Worker must:

- contact the participant to schedule a home visit;
- complete the recertification package with the participant at the home visit;
- give the participant a **W-113K** listing any outstanding documents required to complete the recertification determination;
- enter the recertification information in POS upon return to the Job Center; and
- follow the same process as for other CA recertifications.

If the participant is not at home for the recertification appointment, the designated JOS/Worker must post a case comment in POS or NYCWAY indicating that client was not at home. The case should be closed through POS using WMS Closing Code **G20** (Failure to Recertify–Home Visit).

If, upon receipt of the Notification of Recertification Appointment (**W-908T**), a participant who is not currently designated as HVN/HB calls and requests a home visit, ask if the disability is temporary and the expected duration of the disability.

If the disability is expected to last less than 30 days and if the in-office interview can be held within the required recertification timeframe, reschedule the in-office recertification appointment.

If the in-office interview cannot take place within this timeframe, schedule a home visit to conduct the recertification interview.

If the participant requests HVN status at recertification, follow the procedure starting on page 2 (except for Expedited SNAP).

Non Cash Assistance Supplemental Nutrition Assistance Program (NCA SNAP) Requests for Home Visits

An NCA SNAP applicant/participant may contact a center at any time to request a home visit. The NCA SNAP Worker should inform the applicant/participant requesting a home visit of the various options available for submitting an application including mail, fax, authorized representative or on-line application. If the applicant/participant does not accept any of these options, the NCA SNAP Worker must contact the Center Director or Designee.

The Center Director Designee must annotate the HVN/HB request and contact information on the designated log and:

- if an application was received or the individual is a current participant, access POS and in the Medical screen answer "**Y**" to the question "Is any adult in the household homebound or requesting a home visit?";
- select the individual(s) who made a request for HVN/HB in the "Who" drop down menu; and
- once the request is recorded, access the Employability Code Determination Window to ensure that the HVN/HB individual receives the employability code **WE** (Work Regulations Exempt).

Division of Supplemental Nutrition Assistance Services will request that the Special Project Center make a home visit.

For SNAP applicants and participants, the Center Director/Designee must forward the HVN/HB request to the Division of Supplemental Nutrition Assistance Program Services' Central Office Designee via email to:

- Margaret Rhoden (rhodenm@hra.nyc.gov) and
- Jennifer Powell (powellj@hra.nyc.gov).

Both individuals must be copied on the email. The subject line of the email should be HVN/HB Request.

The Division of Supplemental Nutrition Assistance Program Services' Central Office Designee will ensure that:

- all requests for home visits are documented;
- applicants/participants have been told that SNAP rules do not require an in-person interview;
- alternatives to a home visit for applicants which include applying via mail, fax, on-line, or by assigning an authorized representative have been offered;
- alternatives to a home visit for participants which include recertifying by mail/fax and telephone or by assigning an authorized representative have been offered;
- applicant/participants have been offered interviews by telephone;
- the homebound question in POS has been answered "Yes" for the appropriate individual and the employment code **WE** is assigned upon case acceptance;
- if an alternative to a home visit is accepted and the applicant/participant still wishes to be coded HVN, forms **FIA-1028**, **HRA-108**, **CAS-102**, **CAS-103** and a return envelope should be sent for the applicant/participant's medical provider to return within 20 calendar days;

- the SNAP application/recertification packet is sent to the applicant or participant to complete, if appropriate;
- if none of the alternatives to a home visit are viable, a home visit is scheduled and an email is sent to the HVN Liaison at the Special Project Center to request that a home visit be made at the predetermined time.

The Special Project Center

The Special Project Center will:

- conduct the home visit and provide the application/recertification packet, as appropriate, and the HVN/HB documents/forms (listed on page 4 of this procedure);
- complete the **CAS-102** with the applicant/participant;
- request that the applicant/participant complete and sign the **HRA-108** if assistance is needed to obtain medical documentation; and
- ask the client to return any outstanding HVN/HB documentation in the postage paid envelope provided.

If the applicant/participant refused to sign **HRA-108**, the Special Project Center HVN Liaison must:

- ensure that the individual was informed that assistance to secure medical documentation cannot be provided without a signed **HRA-108** and that he/she must assume full responsibility to return complete medical documentation to FIA;
- write "Refused to Sign" across the front of the **HRA-108** form;
- scan and index it with the other HVN/HB documents; and
- include the unsigned **HRA-108** in the packet emailed to CAS.

After the home visit, the Special Project Center HVN/HB Liaison will:

- confirm that the case is registered and the interview is completed in SNAP POS;
- ensure that all collected HVN/HB documents are scanned and indexed in the viewer; and
- send the email to CAS to notify them of the HVN/HB request and that the completed HVN/HB packet is available for CAS' assessment.

Request for assistance to obtain medical documentation

- If assistance in obtaining medical documentation is requested, the Special Project Center staff will send an email to CAS. The email will include the following:

- "HVN/HB Request for Assistance with Medical Documentation" in the subject line and
- the body of the email should state, "An HVN/HB status determination is requested for the client(s) listed below";
- use a table to list each client's name (last, first), case number, the HVN documents available in the Viewer, and confirm the **FIA-1028L** was attached to the email. See the example below:

	Name	**Case Number**	**HVN Documents**	**FIA-1028L**
1	Smith, John	#1234567	HRA-108, 102, 103	See attached
2	Doe, Jane	#8910112	HRA-108, 102, 103	See attached

A signed copy of the scanned form **HRA-108** must be attached.

Once the Division of Supplemental Nutrition Assistance Program Services' Central Office Designee is notified that all required documentation has been received or collected, and scanned and indexed into the viewer, he/she must email CAS/ORA via CAS ADA mailbox and request an HVN/HB status determination. The subject line of the email should be HVN/HB Request Documents.

Note: Appropriate signed medical documentation received on a medical provider's letterhead may be accepted in lieu of form **CAS-103**.

If documents to support HVN/HB status are not returned, and the applicant/participant did not indicate on the **CAS-102** that he/she has submitted a supportive housing application (**HRA-2010e**) or completed a WeCARE medical assessment within the past twelve months, the Division of Supplemental Nutrition Assistance Program Services' Central Office Designee must:

- mail out the **FIA-1028a** indicating that HVN/HB status is denied because no medical documentation was received and the **HRA-102**;
- after the 20 day appeal timeframe has expired, submit a request to the POS Help Desk for removal of the homebound indicator;
- access the Employability Code Determination Window to ensure that the applicant's/participant's employability code is correct.

Under no circumstance should a case be denied CA or SNAP for failure to submit medical documentation or the CAS forms as a result of an HVN/HB request. Failure to submit medical documentation or CAS forms does not affect the individual's eligibility for CA or SNAP. Any questions about the HVN/HB status determination process for NCA SNAP Center Directors should be directed to Margaret Rhoden at (929) 221-6933.

Requests to Withdraw HVN/HB Status for NCA SNAP Cases

If an NCA SNAP applicant/participant contacts a Center to request removal of his/her Homebound Status, the Worker must:

- send or give the individual a Request for Removal of Homebound Status (**FIA-1028d**) to complete and return;
- annotate the POS case record to indicate that the individual requested to withdraw his/her HVN/HB status;
- scan and index the **FIA-1028d**; and
- contact the Division of Supplemental Nutrition Assistance Program Services' Central Office.

The Division of Supplemental Nutrition Assistance Program Services' Central Office Designee must:

- review and confirm the individual's request for removal of HVN/HB status;
- notify the FIA Operations Deputy Commissioner's Office by forwarding a copy of the completed **FIA-1028d** to the "FIA ADA" mailbox (the subject line of the email should read "Request to Withdraw HVN/HB Status for client's name and case number"). The Deputy Commissioner's Designee will send the individual an **FIA-1028e** and a Request for an Appeal of a Reasonable Accommodation (**HRA-102**);
- connect to the applicant/participant's Center via the POS Portal and access his/her case to enter a detailed case comment using the "SNAP Application Interview" activity for applicants and the "SNAP Change Case Data" activity for participants;
- access the Employability Code Determination Window to ensure that the applicant's/participant's employability code is correct;
- suspend the case activity; and
- submit a request to the POS Help Desk for removal of the homebound indicator.

The POS Help Desk will submit the request to MIS for removal of the homebound indicator. MIS will remove the indicator using the "Home Visit Needed/Homebound Status Removal" activity.

Once MIS confirms that the HVN/HB indicator has been removed, the Division of Supplemental Nutrition Assistance Program Services' Central Office Designee must:

- resume the suspended "SNAP Application Interview" or "SNAP Change Case Data" activity; and
- access the "Employability Code Determination Window" and the TAD to review the applicant's employability code and the household's homebound indicator.

If the casehead is no longer homebound, the Homebound Indicator on the TAD should read "**N**".

Homebound Requests When Home Visit is Not Needed

If an individual requests HB/HVN status and is willing to do an interview by telephone, the SNAP Worker will:

The SNAP TIPS location or the individual's Home Center will send out the CAS forms when the request is received.

- access POS and in the Medical screen answer "**Y**" to the question "Is any adult in the household homebound or requesting a home visit?";
- select the individual(s) who made a request for HVN/HB in the "Who" drop down menu;
- once the request is recorded, access the "Employability Code Determination Window" to ensure that the HVN/HB individual receives the employability code **WE** (Work Regulations Exempt);
- mail the individual the **HRA-108**, **CAS-102**, and the **CAS-103** forms along with a self addressed returned envelope;
- request medical documentation to support their homebound status (If the individual is coded **WE** [Work Exempt] there might already be medical documentation in the OneViewer).

Once the CAS forms and/or medical documentation is received, the SNAP Worker must:

- scan and index the documents into the OneViewer;
- inform the Center Director Designee who must annotate the HVN/HB request and contact information on the designated log;
- the Center Director Designee will alert the Division of Supplemental Nutrition Assistance Program Services' Central Office Designee that the documents are available for CAS review.

The Division of Supplemental Nutrition Assistance Program Services' Central Office Designee must:

- ensure that all of the required documents are available in the OneViewer;
- send an email to CAS informing them of the documents available for an HVN/HB review;
- if homebound status is subsequently approved, ensure that the POS HVN/HB question is answered with a **Y** and that the employability code **WE** (Work Rules Exempt) is present.

Outcome of CAS Review

CA Cases

For CA cases, refer to **Attachment B** for all HVN/HB outcome codes

Once an HVN/HB clinical determination is made on a CA case, CAS will notify the FIA Operations Deputy Commissioner's office via an email to the FIA ADA mailbox within five (5) business days. The Deputy Commissioner's office will notify the Executive Regional Manager of the determination.

Note: The **192N** is used with failure to provide medical documentation or the medical documentation submitted is not acceptable

Possible determinations and action codes include:

192F HVN/HB Temporary Exemption (90, or 180 days),
192L HVN/HB Status Approved (365 days),
192U HVN/HB Status Approved for More Than 365 days,
192N HVN/HB Status Not Approved

NYCWAY will auto-generate the **FIA-1028a** and **HRA-102** to inform the applicant/participant of the HVN/HB status determination.

CA-HVN/HB status not approved

The HVN/HB status will remain in place for CA applicants and participants whose HVN/HB status request is not approved (**192N**). These individuals must continue to be treated as HVN/HB until the appeal process is complete.

When CA applicants/participants are not approved for HVN/HB status and do not file an appeal within 20 days, Action Code **192E** (HVN/HB Status End/No Appeal Filed) will autopost in NYCWAY. Non-exempt individuals will be placed on the unengaged (**UNENG**) worklist and sent a Mandatory Appointment for Evaluation of Work Activity Form (**W-584K**) for an engagement status assessment.

NCA SNAP Cases

Once an HVN/HB clinical determination is made on an NCA SNAP case, CAS will notify the FIA Operations Deputy Commissioner's office via an email to the FIA ADA mailbox within five (5) business days. The Deputy Commissioner's Designee will:

- notify the applicant/participant by completing Form **FIA-1028a** indicating the appropriate status determination;
- scan and index Form **FIA-1028a** and **HRA-102** into the viewer;
- mail the completed **FIA-1028a** and form **HRA-102** to the applicant/participant; and
- notify the Division of Supplemental Nutrition Assistance Program Services' Central Office about the determination.

NCA SNAP-HVN/HB status disapproved

When NCA SNAP applicants/participants are not approved for HVN/HB status, the answer to the question "*Is any adult in the household homebound or requesting a home visit*?" must remain "**Y**" in POS and the individual must continue to be treated as HVN/HB until the appeal process is complete.

If no appeal is filed, the Designated Worker must:

- contact the POS Help Desk to change the answer of "Y" to "N" for the question "Is any adult in the household homebound or requesting a home visit?";
- If the HVN/HB request was for the casehead, once the Help Desk removes the casehead from the **Who** list for the question "Is any adult in the household homebound or requesting a home visit?" update the TAD screen in POS to remove the "**Y**" in the WMS HB field.

Appeals

Filing an Appeal

Requests for an appeal of an HVN/HB status determination (**HRA-102**) may be completed by the applicant/participant and either mailed to the address below, faxed or emailed to the ADA Compliance Officer. The applicant/participant may call Office of Constituent Services (OCS) at (212) 331-4640 or fax OCS at (212) 331-4686 to obtain assistance in completing the **HRA-102**.

ADA Compliance Officer
Office of Legal Affairs
Privacy and ADA Compliance Unit
180 Water Street, 17th Floor
New York, New York 10038
Fax number:(917) 639-0333
Email: adaola@hra.nyc.gov

If the appeal is sent directly to the Job Center or NCA SNAP Center, the **HRA-102** must be emailed to the above ADA/OLA mailbox.

For CA cases, refer to **Attachment B** for NYCWAY action codes

Note: CA and NCA SNAP individuals who file an appeal must continue to be treated as HVN/HB during the appeal process.

Appeal filed

Once an appeal is filed, the Deputy Commissioner's Designee will:

For CA

- post Action Code **192A** (Appeal Filed) in NYCWAY.

For NCA SNAP

- contact the Division of SNAP Services Central Office to ensure that the answer to the question "*Is any adult in the household homebound or requesting a home visit*" in POS remains "**Y**" until the outcome of the appeal.

If the client requests additional time to submit documentation and the request is approved, enter Action Code **19TA** (Additional Time Requested To Submit Document) with a Future Action Date in NYCWAY.

Appeal denied

When an appeal is denied, the Deputy Commissioner's Designee will:

For CA

- post Action Code **192D** (HVN/HB Appeal Denied) which will place the individual on the **UNENG** worklist.

For NCA SNAP

- contact the POS Help Desk for removal of the answer "**Y**" to the question "*Is any adult in the household homebound or requesting a home visit?*". If the denied HNV/HB request was for the casehead, the NCA SNAP Designated Worker must also update the TAD screen in POS to remove the "**Y**" in the WMS homebound indicator field.

Renewal of HVN/HB Status

Participants who are currently granted temporary HVN/HB status for 90,180, 365 days, or more than 365 days, must submit new updated documentation prior to the expiration of the current HVN/HB status period in order to continue/renew the HVN/HB status.

Refer to **Attachment A** for a description of all notices

Action Code **19EN** (HVN/HB Exemption Expiration Notice) will autopost in NYCWAY 30 days prior to the expiration of the Home Visits Needed/Homebound Status and will generate the Notification of Expiration of Home Visits Needed/Homebound Status form (**FIA-1028k**) which will be sent to the CA and NCA SNAP participant. The **FIA-1028k** mailing includes a **CAS-103** and a postage paid return envelope.

If the participant fails to respond by the exemption Future Action Date, NYCWAY will autopost Action Code **192B** (HVN/HB Expired), and the participant will be called in for an engagement assessment and potential participation in a work activity, the call-in will be a batch call-in generated by Action Code **19DI** (HVN/HB Completed-Batch Call In) which will autopost after the **192B**.

If the participant requests a renewal of his/her HVN/HB status, the designated JOS/Worker in the Special Project Center will post Action Code **192Q** (HVN/HB Exemption Renewal Request) forward submitted/returned documents to CAS, and follow the same process as for initial HVN/HB status request.

If the client requested renewal of the HVN/HB status but needs additional time to submit updated documentation, enter Action Code **19TE** (Additional Time Require For Document) with a Future Action Date in NYCWAY.

For CA and NCA SNAP cases, the Special Project Center will process HVN/HB renewals, forward submitted/returned documents to CAS, and follow the same process as for initial HVN/HB status requests.

Participants who requested a renewal of their HVN/HB status but do not submit new current documentation to support the continued need for HVN/HB status and have not requested an extension of time to obtain the required medical documentation must be sent the **FIA-1028e** notifying them of the removal of their HVN/HB status, and an **HRA-102** instructing them how to appeal the denial determination.

If no appeal is filed, CA participants who are work rules required will be called-in via **M-584K** for an engagement assessment.

While there is an open Action Code **192P**/**192Q** in NYCWAY, the CA case cannot be transferred to another center.

Separate Supplemental Nutrition Assistance Program Benefit Determinations

Applicants

If a CA applicant who requests HVN/HB status is determined ineligible for CA but eligible for SNAP, POS will have the Home Visit Needed Question set to "Yes" on the corresponding SNAP case if the separate determination is done in the buddy SNAP site.

Participants

If there is a homebound indicator in WMS because the home visit needed/homebound individual is the casehead, when the CA case is closed but remains eligible for SNAP, the homebound indicator will transfer to the new NCA SNAP case created during the automated separate SNAP determination process.

Effective Immediately

Attachments:

Attachment A	Home Visit Needed/Homebound Process Forms Guide (Rev. 3/7/14)
Attachment B	NYCWAY Action Codes for the Home Visit Needed/Homebound (HVN)/HB) Process (Rev. 3/7/14)
FIA-1028 (E)	Home Visit Needed/Homebound Determination Process (Rev.1/24/13)
FIA-1028 (S)	Home Visit Needed/Homebound Determination Process (Spanish) (Rev. 1/24/13)
FIA-1028a	Notification of Home Visit Needed/Homebound Status Determination (Rev. 2/6/13)
FIA-1028a (S)	Notification of Home Visit Needed/Homebound Status Determination (Spanish) (Rev. 2/6/13)
FIA-1028b (E)	Home Visit Appointment Notice (CA Application) (Rev. 6/28/13)
FIA-1028b (S)	Home Visit Appointment Notice (CA Application) (Spanish) (Rev. 6/28/13)
FIA-1028c (E)	Mandatory Appointment Notice (Non Cash Assistance Supplemental Nutrition Assistance Program [SNAP] Application) (Rev. 7/2/13)
FIA-1028c (S)	Mandatory Appointment Notice (Non Cash Assistance Supplemental Nutrition Assistance Program [SNAP] Application) (Spanish) (Rev. 7/2/13)

FIA-1028d (E)	Request to Remove Home Visit Needed/Homebound Status (Rev. 3/03/11)
FIA-1028d (S)	Request to Remove Home Visit Needed/Homebound Status (Spanish) (Rev. 3/03/11)
FIA-1028e (E)	Notice of Removal of Home Visit Needed/Homebound Status (Rev. 3/7/14)
FIA-1028e (S)	Notice of Removal of Home Visit Needed/Homebound Status (Spanish) (Rev. 3/7/14)
FIA-1028h (E)	Notice of Scheduled Home Visit (Rev. 7/10/13)
FIA-1028h (S)	Notice of Scheduled Home Visit (Spanish) (Rev. 7/10/13)
FIA-1028i (E)	Documentation Request for Home Visits Needed/Homebound Requests (Rev. 1/24/13)
FIA-1028i (S)	Documentation Request for Home Visits Needed/Homebound Requests (Spanish) (Rev. 1/24/13)
FIA-1028k (E)	Notification of Expiration of Home Visit Needed/Homebound Status (Rev. 1/24/14)
FIA-1028k (S)	Notification of Expiration of Home Visit Needed/Homebound Status (Spanish) (Rev.1/24/14)
FIA-1028L (E)	Home Visit Needed (HVN)/Homebound (HB) Status Liaison Checklist of Required Documents for CAS Review (Rev. 7/10/13)
FIA-1028n (E)	Missed Homebound Assessment Interview (Rev. 3/7/14)
FIA-1028n (S)	Missed Homebound Assessment Interview (Spanish) (Rev. 3/7/14)
CAS-102	Home Visit Needed Request Activities of Daily Living -Client Information Form
CAS-103	Home Visit Needed Request Clinician Assessment Form
CAS-300	Medical Provider Appointment Wellness, Comprehensive Assessment, Rehabilitation and Employment (WeCARE) Referral for Assessment
CAS- 311	Home Visit Needed Wellness, Comprehensive Assessment, Rehabilitation and Employment (WeCARE) Assessment Cancellation
HRA-102 (E)	Request for an Appeal of a Reasonable Accommodation Determination (Rev. 1/18/13)
HRA-102 (S)	Request for an Appeal of a Reasonable Accommodation Determination (Spanish) (Rev. 1/18/13)

HRA-108 (E)	HIPAA Authorization for the Disclosure of Individual Health Information
HRA-108 (S)	HIPAA Authorization for the Disclosure of Individual Health Information (Spanish)

Attachment A

Home Visit Needed/Homebound Process Forms

Form #	Form Name	Purpose/Instruction
FIA-1028	**Home Visit Needed/Homebound Determination Process**	Must be given or mailed to all applicants/participants who request HVN/HB status. This form explains the steps in the HVN/HB process. Given by JOS for CA. Mailed by Yama Philip's Designee or brought to home by PAA for NCA SNAP.
FIA-1028a	**Notification of Home Visit Needed/Homebound Status Determination**	HVN/HB status determination must be mailed to applicants/participants after the CAS clinical determination is received. It provides the status determination and includes instructions about how to file an appeal of the determination. Form **HRA-102** (Request for an Appeal) must be included in the mailing. Mailed by the Designated Worker in the FIA Operations Deputy Commissioner's Office.
FIA-1028b	**Home Visit Appointment Notice (Cash Assistance Application)**	Must be sent to notify a CA applicant that a home visit appointment has been scheduled. Used when the applicant cannot be reached by telephone. Mailed by Director's Designee.
FIA-1028c	**Mandatory Appointment Notice (Non Cash Assistance Food Stamp Application)**	Must be sent to the NCA SNAP applicant who requests an in person application interview who did not report contact information. The Notice explains that an in person appointment is not necessary for NCA SNAP applicants and that the applicant or authorized representative may conduct the eligibility interview on the telephone. A telephone appointment date and time is indicated on the notice. Mailed by Yama Philips' Designee.
FIA-1028d	**Request to Remove Home Visit Needed/Homebound Status**	Must be sent or given to applicants/participants currently coded as homebound who request that homebound status be removed. The form must be signed by the applicant/participant and be returned to document the request for removal of status. Give/sent by Director's Designee for CA or Yama Philips's Designee for NCA SNAP.
FIA-1028e	**Notice of Removal of Home Visit Needed/Homebound Status**	Must be sent to participants currently in HVN/HB (**192H**) status to notify him/her that HVN/HB status will be removed and the reason for the removal. Participants are also given instructions for appealing the removal of HVN/HB status. Form **HRA-102** (request for an appeal) must be included in the mailing. Mailed by Director's Designee for CA or Yama Philips's Designee for NCA SNAP.
FIA-1028h	**Notice of Scheduled Home Visit**	Must be sent to applicants/participants who cannot be reached by phone to notify them of a date for the home visit.
FIA-1028i	**Documentation Request for Home Visits Needed/Homebound Requests**	Must be left with the applicant/participant at the home visit as documentation that HVN/HB forms were provided. For NCA SNAP applicants/participants, if a home visit is not necessary, the form may be mailed.
FIA-1028k	**Notification of Expiration of Home Visit Needed/ Homebound Status**	Must be sent to the applicant/participant 30 days before expiration of HVN/HB status with instructions about how to renew the status.
FIA-1028L	**Home Visit Needed (HVN)/Homebound (HB) Status Liaison Checklist of Documents for CAS Review**	Must be completed by the HVN Liaison and included in the email informing CAS of the documents available in the OneViewer for review.

Attachment A

Form #	Form Name	Purpose/Instruction
FIA-1028n	**Missed Homebound Assessment Interview**	This form is mailed to the applicant/participant if the applicant/participant is not home at the time of the scheduled home visit appointment. This form indicates the date of the missed appointment, instructs the applicant/participant to contact HRA to reschedule the appointment and to verify that s/he still wants to pursue the Request for HVN/HB status and/or the application. The form also informs the applicant/participant that failing to contact HRA may result in the denial of their HVN/HB request.
HRA -102	**Request for an Appeal of a Reasonable Accommodation Determination**	Must be sent to the applicant/participant with form **FIA-1028a** or form **FIA1028e**. It must be returned by applicant/participant to the OLA/ADA Compliance Officer in order to formally request an appeal. Sent by the Designated Worker in the FIA Operations Deputy Commissioner's office.
HRA-108	**HIPPA Authorization for the Disclosure of Individual Health Information**	The applicant/participant must sign this authorization to allow HRA to communicate with his/her medical provider to request information about their medical condition, if the applicant/ participant is requesting HRA's assistance to obtain medical documentation. This authorization will also allow CAS to request health information from the medical provider if the applicant/participant requested HRA's assistance in obtaining medical documentation. Two copies of this form must be mailed/brought to the applicant/participant. One copy is returned to the Center and the other copy is for the medical provider. Brought to the home visit by JOS/Worker for CA. Mailed by NCA SNAP Designee or brought to the home visit by an SPC Worker for NCA SNAP.
CAS- 102	**HVN Request Activities Of Daily Living**	At the home visit, the Designated Worker must ask the applicant/participant the questions on this form and record the answers. The answers will help CAS make a clinical determination about HVN/HB status. For NCA SNAP applicants who use an alternative process and don't need a home visit, the form must be sent to the individual with a request that it be sent back with the other required HVN/HB forms. Brought to the home visit by the JOS/Worker for CA. Mailed by NCA SNAP Designee or brought to the home visit by an SPC for NCA SNAP.
CAS-103	**HVN Request Clinician Assessment Form**	This form must be given or sent to the applicant/participant to take/send to their medical provider. The information captured on this form will help to document the need for HVN/HB status. Brought to the home visit by the JOS/Worker for CA. Mailed to the home by NCA SNAP Designee/ or brought to the home visit by an SPC for SNAP.
CAS-311	**HVN Wellness, Comprehensive Assessment, Rehabilitation and Employment (WeCARE) Assessment Cancellation**	This form must be given or sent to the applicant/participant to confirm a request for the cancellation of a scheduled WeCARE appointment. The form also instructs the applicant/participant that he/she must submit documentation to support the HVN/HB status request.

Attachment B

NYCWAY Action Codes for the Home Visit Needed (HVN) Homebound (HB) Request Process

Action Code	Description	Purpose/Instruction
192A	**HVN/HB Appeal Process**	Deputy Commissioner's Designee enters code in NYCWAY if an appeal is filed
192B	**HVN/HB Status Expired**	NYCWAY autopost
192D	**HVN/HB Appeal Denied**	Deputy Commissioner's Designee enters code in NYCWAY if an HVN/HB appeal is denied
192E	**HVN/HB Status End/No Appeal Filed**	NYCWAY autopost
192F	**HVN/HB Temporary Exemption (90 or 180 days)**	Deputy Commissioner's Designee enters code in NYCWAY if HVN/HB status is temporarily approved
192G	**HVN/HB Temporary Exemption (192F)Appeal Process**	Deputy Commissioner's Designee enters code in NYCWAY if the granting of a temporary exemption is appealed
192K	**HVN/HB Appeal of Temporary Exemption Status (192F)Denied**	Deputy Commissioners Designee enters in NYCWAY if an appeal of temporary exemption status is denied.
192L	**HVN/HB Status Approved (365 days)**	Deputy Commissioner's Designee enters in NYCWAY if HVN/HB status is approved for 365 days
192N	**HVN/HB Status Not Approved**	Deputy Commissioner's Designee enters code in NYCWAY if HVN/HB Status is not approved
192P	**HVN/HB Status Request Pending Documentation**	System posted for ongoing CA cases by JOS/Worker entering "YES" to the homebound question in POS
19Si	**HVN/HB Single Issue One Shot Deal Request Pending Documentation**	System posted for One-Shot Deal cases by JOS/Worker entering "**YES**" to the homebound question in POS. Self-completing
192U	**HVN/HB Approved for More Than 365 days**	Deputy Commissioner's Designee enters in NYCWAY if HVN/HB status is approved for more than 365 days
192W	**HVN/HB Status Request Withdrawn**	Deputy Commissioner's Designee enters code in NYCWAY if the request for HVN/HB status is withdrawn
19DO	**Help Requested to Obtain Documents**	Posted by JOS/Worker if help is needed to obtain medical documents
19DC	**Complete Document Packet Sent to CAS**	Posted by the HVN/HB Liaison indicating that the email was sent to CAS informing them that the documents are available in the OneViewer
19ND	**HVN Medical Documentation Not Returned**	Posted by the HVN/HB Liaison if the applicant/participant did not submit any medical documentation to support HVN/HB status within 20 calendar days.
19EE	**HVN/HB Administrative Removal**	Posted only by MIS (NYCWAY Help Desk when the HVN/HB code was entered in error).

Attachment B

NYCWAY Action Codes for the Home Visit Needed (HVN) Homebound (HB) Request Process

Action Code	Description	Purpose/Instruction
99WA	**HVN Referral to WeCARE – Applicant**	Batch referral Auto-Posted by NYCWAY
19WA	**HVN Referral to WeCARE – Participant**	Batch referral Auto-Posted by NYCWAY
99WN	**Cancel WeCARE HVN Request – Applicant**	Posted by WeCARE vendor when applicant calls to cancel the appointment
19WN	**Cancel WeCARE HVN Request – Participant**	Posted by WeCARE vendor when participant calls to cancel the appointment
99WC	**HVN WeCARE Referral Accepted (applicant)**	Posted by JOS/Worker upon return to Center
19WC	**HVN WeCARE Referral Accepted (participant)**	Posted by JOS/Worker upon return to Center
19WO	**HVN WeCARE Outreach**	WeCARE vendor posts for FTR to appointment
19WB	**HVN WeCARE Outreach Successful**	WeCARE vendor posts
19WR	**HVN WeCARE Outreach Unsuccessful**	Auotposts if outreach is not successful
19WX	**Cancel WeCARE HVN Request**	Posted by CAS staff if WeCARE appointment is cancelled
19PW	**WeCARE Assessment in Past 12 Months**	Posted by Director's Designee/ HVN/HB Liaison when no documents have been provided at the end of the 20-days but the WeCARE box is checked on **CAS-102**
19PH	**Supportive Housing Application (HRA 2010e) Submitted within Past 12 Months**	Posted by Director's Designee/ HVN/HB Liaison when no documents have been provided at the end of the 20-days but the supportive housing application box is checked on **CAS-102**
908H	**HVN/HB Recertification**	Autoposted in NYCWAY to prevent the scheduling of an in-office recertification appointment
19TR	**Additional Time Required For Document**	Posted by JOS/Worker if the applicant/participant request additional time to obtain documents at the initial request for HVN/HB status.
19TA	**Additional Time Required For Appeal**	Posted by the designated liaison in the FIA Operations Deputy Commissioner's Office if the applicant/participant requests additional time to obtain documents following an HVN/HB appeal request.
19EN	**HVN/HB Exemption Expiration Notice**	NYCWAY autopost
19DI	**HVN/HB Completed-Batch Call In**	NYCWAY autopost
192Q	**HVN/HB Exemption Renewal Request**	Posted by JOS/Worker if the participant requests an extension to submit documents once the 19EN has been posted and the FIA-1028L has been mailed.

NYC Human Resources Administration Department of Social Services | Family Independence Administration

Date: _____
Name: _____
Address: _____
_____
Date of Birth: _____
Case Number: _____
Case Name: _____
Center: _____

Home Visits Needed/Homebound Determination Process

You have requested that the Human Resources Administration (HRA) classify you as Home Visits Needed (HVN)/Homebound (HB). In order to be classified as HVN/HB, you must provide medical documentation that confirms that you have a physical or mental health impairment that restricts your ability to leave your place of residence or neighborhood, or are otherwise unable to appear at a Center.

At the requested home visit, you should provide the HRA Representative with any medical documentation you have to support your claim of HVN/HB.

The HRA Representative will interview you to complete the Home Visit Needed/Activities of Daily Living Form (**CAS-102**). He/she will also provide you with:

- Home Visit Needed/Clinician Assessment Form (**CAS-103**) for your medical provider to complete;
- HIPAA Authorization for the Disclosure of Individual Health Information (**HRA-108**); and
- A postage paid envelope for your medical provider to return Form **CAS-103** to HRA within 20 days.

If you need HRA's assistance in getting your medical documentation, you must sign Form **HRA-108** and give HRA your medical provider's contact information. HRA will contact your medical provider and request documentation to support your claim.

HRA will review all documentation provided by you and your medical provider and send you a written notice regarding our determination of your request. Included in the notice will be instructions for filing an appeal if you disagree with HRA's determination.

I hereby acknowledge receipt of the following forms: **HRA-108** – Home Visit Needed/Authorization for Release of Health Information Form, **CAS-102** – Home Visit Needed/Activities of Daily Living Form, **CAS-103** – Home Visit Needed/Clinician Assessment Form.

_____ _____
Signature Date

FIA-1028 (S) 01/24/2013
LLF

NYC Human Resources Administration Department of Social Services | Family Independence Administration

Fecha: _____

Nombre: _____

Dirección: _____

_____

Fecha de Nacimiento: _____

Número del Caso: _____

Nombre del Caso: _____

Centro: _____

Trámite de Necesidad de Visitas al Hogar/Determinación de Confinamiento al Hogar

Usted ha solicitado que la Administración de Recursos Humanos (HRA) le clasifique como Necesidad de Visitas al Hogar(HVN)/Confinamiento al Hogar (HB). Para ser clasificado como HVN/HB, usted tiene que proporcionar documentación médica que compruebe que usted tiene un impedimento físico o de psicológico que restringe su capacidad de transportarse de su domicilio o vecindario, o que usted no puede comparecer en el Centro por otra razón.

Durante la visita al hogar solicitada, usted debe proporcionarle al Representante de la HRA cualquier documentación médica que usted posea para justificar su petición de HVN/HB.

El Representante de la HRA le entrevistará para llenar el formulario Home Visit Needed/Activities of Daily Living Form (**CAS-102**). Además, el representante le proporcionará:

- Formulario Home Visit Needed/Clinician Assessment Form (**CAS-103**) para que lo llene su proveedor médico;
- Formulario de Autorización HIPAA para la Divulgación de Información Médica Personal (**HRA-108 [S]**); y
- Un sobre con franqueo prepagado para que su proveedor médico devuelva el formulario **CAS-103** a la HRA dentro de 20 días.

Si usted necesita la ayuda de la HRA para obtener su documentación médica, debe firmar el formulario **HRA-108 (S)** y proporcionarle a la HRA la información de contacto de su proveedor médico. La HRA se comunicará con su proveedor médico y solicitará documentación que justifique su propósito.

La HRA revisará toda la documentación proporcionada por usted y su proveedor médico y le enviará a usted un aviso por escrito de nuestra determinación respecto a su petición. El aviso incluirá instrucciones para presentar una apelación en caso de que usted esté en desacuerdo con la determinación de la HRA.

Por el presente acuso recibo de los siguientes formularios: **HRA-108 (S)** – Formulario de Autorización HIPAA para la Divulgación de Información Médica Personal Form, **CAS-102 (S)** – Solicitud de necesidad de visitas domiciliarias/Actividades de la vida diaria - Formulario de información del cliente, **CAS-103** – Home Visit Needed/Clinician Assessment Form.

_____ _____

Firma Fecha

NYC Human Resources Administration Department of Social Services | Family Independence Administration

FIA-1028a (E) 02/06/2013 LLF

Date: _____

Case Number: _____

Case Name: _____

Name: _____

Date of Birth: _____

Center: _____

Notification of Home Visit Needed/Homebound Status Determination

Our records show that _____ has requested Home Visit Needed (HVN)/Homebound (HB) status.

The Human Resources Administration's (HRA) determination concerning your request for HVN/HB status is as follows:

- ☐ Your request for HVN/HB status has been approved for **more than one year.** HRA may contact you in the future to obtain updated medical documentation.
- ☐ Your request for HVN/HB status has been approved for **12 months** (one year). We will contact you before your **12 months** (one year) expire to determine if your HVN/HB status should be extended.
- ☐ Your request for HVN/HB status has been approved for **6 months**. We will contact you before your **6 months** expire to determine if your HVN/HB status should be extended.
- ☐ Your request for HVN/HB status has been approved for **3 months**. We will contact you before your **3 months** expire to determine if your HVN/HB status should be extended.

Note: You are still required to comply with requests for documentation/verification of your eligibility.

- ☐ Your request for HVN/HB status has been disapproved, because HRA did not receive the required medical documentation to support your claim of HVN/HB status **or** HRA has been unable to obtain the documentation from your provider.
- ☐ Your request for HVN/HB status has been disapproved because HRA has determined that the medical documentation we received does not support HVN/HB status.
- ☐ Your request for HVN/HB status has been disapproved because WeCARE has made the clinical determination that your medical condition(s) do not support HVN/HB status.

Americans With Disabilities Act (ADA) Appeal Process

You or your authorized representative may appeal HRA's decision about your HVN/HB status. To file an appeal, please submit your request for an appeal in writing within **20 calendar days** of this determination. Individuals who need assistance filing their appeal because of a physical and/or mental condition may contact the Office of Constituent Services for assistance at (212) 331-4640 or may e-mail the appeal to constituentaffairs@hra.nyc.gov. For your convenience, we have enclosed the Request for an Appeal of a Reasonable Accommodation Determination (Form **HRA-102**). You may complete the **HRA-102** and submit it to the address below. Appeal requests may be directed to:

ADA Compliance Officer
180 Water Street, 17th Floor
New York, New York 10038
Fax: (917) 639-0333
Email: adaola@hra.nyc.gov

Until HRA makes a decision on your filed appeal, you will not be required to attend any in-person appointments at an HRA office. If you do not file an appeal, you may be required to appear for an appointment.

NYC Human Resources Administration Department of Social Services | Family Independence Administration

FIA-1028a (S) 02/06/2013 LLF

Fecha: _____

Número del Caso: _____

Nombre del Caso: _____

Nombre: _____

Fecha de Nacimiento: _____

Centro: _____

Aviso de Determinación de Estado de Necesidad de Visitas/Confinamiento al Hogar

Nuestros archivos indican que _____ ha solicitado un estado de Necesidad de Visitas/Confinamiento al Hogar (HVN/HB).

La decisión de la Administración de Recursos Humanos (HRA) respecto a su petición de estado de HVN/HB es la siguiente:

- ☐ Su petición de estado de HVN/HB ha sido aprobada por **más de un año**. La HRA podría comunicarse con usted en un futuro para obtener documentación médica actualizada.
- ☐ Su petición de estado de HVN/HB ha sido aprobada por **12 meses** (un año). Nos comunicaremos con usted antes de que sus **12 meses** (un año) se terminen para determinar si su estado de HVN/HB debiera ser extendido.
- ☐ Su petición de estado de HVN/HB ha sido aprobada por **6 meses**. Nos comunicaremos con usted antes de que sus **6 meses** se terminen para determinar si su estado de HVN/HB debiera ser extendido.
- ☐ Su petición de estado de HVN/HB ha sido aprobada por **3 meses**. Nos comunicaremos con usted antes de que sus **3 meses** se terminen para determinar si su estado de HVN/HB debiera ser extendido.

Aviso: Aún se requiere que usted cumpla con los pedidos de documentación/verificación de su elegibilidad.

- ☐ Su petición de estado de HVN/HB ha sido negada, porque la HRA no recibió la documentación médica necesaria para justificar su reclamación de estado de HVN/HB **o** la HRA no ha podido obtener información de su proveedor médico.
- ☐ Su petición de estado de HVN/HB ha sido negada, porque la HRA ha determinado que la documentación médica que recibimos no justifica su estado de HVN/HB.
- ☐ Su petición de estado de HVN/HB ha sido negada, porque WeCARE ha determinado que su condición(es) médica no justifica su estado de HVN/HB.

Trámite de Apelación de la Ley de Americanos Incapacitados (ADA)

Usted o su representante autorizado pueden apelar esta determinación de la HRA sobre su estado de HVN/HB. Para presentar una apelación, favor de presentar su pedido por escrito dentro de **20 días civiles** de esta determinación**.** Las personas que necesiten asistencia para presentar apelación debido a un problema físico y/o mental pueden comunicarse con la Office de Constituent Services (Oficina de Servicios al los Electores) al (212) 331-4640 o pueden enviar la apelación por correo electrónico a constituentaffairs@hra.nyc.gov. Para su conveniencia, hemos incluido un formulario de Pedido de Apelación de una Determinación de Arreglo Razonable (**HRA-102 [S]**). Usted debe completar el **(HRA-102 [S])** y enviarlo a la dirección indicada abajo. Las solicitudes de apelación pueden presentarse a:

ADA Compliance Officer
180 Water Street, 17th Floor
New York, New York 10038
Fax: (917) 639-0333
Email: adaola@hra.nyc.gov

Hasta que la HRA tome una decisión sobre su apelación presentada, a usted no se le exigirá que asista a ninguna cita en persona en la oficina de la HRA. Si no presenta su apelación, puede que se le exija que asista a una cita.

FIA-1028b (E) 06/28/2013
LLF

NYC Human Resources Administration Department of Social Services | Family Independence Administration

Date: _____

Case Number: _____

Case Name: _____

Telephone: _____

Job Center: _____

Home Visit Appointment Notice

(Cash Assistance Application)

We received your application for Cash Assistance/Supplemental Nutrition Assistance Program (SNAP) benefits on _____.
Date

You have requested that we do an in-person eligibility interview in your home because you are unable to come to an HRA Center.

We have scheduled an in-home interview for you on:

Appointment Date: _____ Time: _____

This is a mandatory eligibility appointment. Failure to keep an initial eligibility interview without good cause can result in the denial of your application. If you are not able to keep this appointment, please call the number above to reschedule your in-home interview.

We have also enclosed the Eligibility Factors and Suggested Documentation Guide (Form **W-119D**). The eligibility factors that must be verified as a condition of eligibility have been checked.

NYC Human Resources Administration Department of Social Services | Family Independence Administration

Fecha: _____

Número del Caso: _____

Nombre del Caso: _____

Teléfono: _____

Centro de Trabajo: _____

Aviso de Cita para Visita al Hogar

(Solicitud de Asistencia en Efectivo)

Hemos recibido su solicitud de Asistencia en Efectivo/beneficios del Programa de Asistencia de Nutrición Suplementaria (SNAP) el _____.
Fecha

Usted ha solicitado que nosotros realicemos una entrevista de elegibilidad en persona en su hogar porque usted no puede presentarse a un Centro de la HRA.

Le hemos programado una entrevista en su hogar para el:

Fecha de la Cita: _____ Hora: _____

Esta es una cita de elegibilidad obligatoria. Si no puede cumplir esta entrevista inicial de elegibilidad si motivo justificada, puede resultar en el rechazo de su solicitud. Si no puede cumplir esta cita, favor de llamar al número indicado arriba para reprogramar su entrevista en el hogar.

Además, hemos adjuntado la Guía de Factores de Elegibilidad y Documentación Sugerida (Eligibility Factors and Suggested Documentation Guide), (Formulario **W-119D [S]**). Los factores de elegibilidad que deben verificarse como condición de elegibilidad han sido marcados.

NYC Human Resources Administration Department of Social Services | Family Independence Administration

Date: _____

Case Number: _____

Case Name: _____

Telephone: _____

NCA SNAP Center: _____

Mandatory Appointment Notice

(Non Cash Assistance Supplemental Nutrition Assistance Program [SNAP] Application)

We received your application for SNAP on _____. You have requested that we
(Date)
do an in-person eligibility interview in your home because you are unable to come to a SNAP Center.

It is not necessary for you to have an in-person interview for SNAP. You or someone you name as an authorized representative can have an interview on the telephone.

We have scheduled a telephone interview for you on:

Appointment Date: _____ Time: _____

And will call you at: _____

If you are not able to keep this telephone interview or would like us to call you or your authorized representative at a different number, please call the number above.

If we are unable to reach you or your authorized representative by telephone, an HRA representative will come to your home on _____ at _____.

This is a mandatory eligibility interview. Failure to keep an initial eligibility interview without good cause can result in the denial of your application. If you are not able to keep this telephone interview, call the number above.

We have also enclosed the Eligibility Factors and Suggested Documentation Guide (Form **W-119 D**). The eligibility factors that must be verified as a condition of eligibility have been checked.

NYC Human Resources Administration Department of Social Services | Family Independence Administration

Fecha: _____

Número del Caso: _____

Nombre del Caso: _____

Teléfono: _____

Centro de SNAP
de No Asistencia en Efectivo: _____

Aviso de Cita Obligatoria

(Solicitud del Programa de Asistencia de Nutrición Suplementaria [SNAP] de No Asistencia en Efectivo)

Hemos recibido su solicitud del SNAP el _____ (Fecha). Usted ha solicitado que nosotros realicemos una entrevista de elegibilidad en persona en su hogar porque usted no puede presentarse a un Centro de SNAP.

No es necesario que usted asista a una entrevista en persona de SNAP. Usted puede asistir a una cita telefónica o puede nombrar a un representante autorizado para ser entrevistado por teléfono en su hogar.

Le hemos programado una entrevista por teléfono el:

Fecha de la Cita: _____ Hora: _____

y lo llamaremos a las: _____

Si usted no puede cumplir esta entrevista telefónica o le gustaría que lo llamemos a usted o a un representante autorizado a un número diferente, por favor llamar al número indicado arriba.

Si no podemos comunicarnos por teléfono con usted o con su representante autorizado, un representante de la HRA lo visitará en su hogar el _____ a las _____.

Esta es una cita de elegibilidad obligatoria. Si no puede cumplir esta entrevista inicial de elegibilidad si motivo justificada, puede resultar en el rechazo de su solicitud. Si no puede cumplir con esta entrevista telefónica, llame al número indicado arriba.

Además, hemos adjuntado la Guía de Factores de Elegibilidad y Documentación Sugerida (Eligibility Factors and Suggested Documentation Guide), (**W-119D [S]**). Los factores de elegibilidad que deben verificarse como condición de elegibilidad han sido marcados.

NYC Human Resources Administration Department of Social Services | Family Independence Administration

Date: _____

Case Number: _____

Case Name: _____

Center Number: _____

Request to Remove Home Visit Needed/Homebound Status

I requested Home Visit Needed (HVN)/Homebound (HB) status, but I do not want to continue to be treated as HVN/HB. I do not want a representative from the Human Resources Administration (HRA) to come to my home for appointments. I understand that by withdrawing my request, I will have to go to HRA for all required in-person appointments, and effective today I may be subject to additional eligibility requirements not yet fulfilled.

Name: _____

Signature: _____

Date: _____

FIA-1028d (S) 03/03/2011
LLF

NYC Human Resources Administration Department of Social Services | Family Independence Administration

Fecha: _____

Número del Caso: _____

Nombre del Caso: _____

Número del Centro: _____

Petición para el Retiro del Estado de Necesidad de Visitas/Confinamiento al Hogar

Yo solicité un Estado de Necesidad de Visitas/Confinamiento al Hogar (HVN/HB), pero ya no deseo continuar ser tratado como Estado de Necesidad de Visitas al Hogar (HVN/HB). No deseo que un representante de la Administración de Recursos Humanos (HRA) visite mi hogar para citas. Entiendo que al retirar mi pedido de Estado de Necesidad de Visitas al Hogar (HVN/HB) tendré que ir en persona al HRA para todas mis citas requeridas, y apartir de hoy yo podría estar sujeto a requisitos adiconales de elegibilidad que aún no se han cumplido.

Nombre: _____

Firma: _____

Fecha: _____

FIA-1028e (E) 03/07/2014
LLF

NYC Human Resources Administration Department of Social Services | Family Independence Administration

Date: _____
Case Number: _____
Case Name: _____
Center Number: _____
Center Phone No.: _____

Notice of Removal of Home Visit Needed/Homebound Status

This notice is to inform you that your Home Visit Needed (HVN)/Homebound (HB) status will be removed effective 20 calendar days from the date of this notice.

The Human Resource Administration (HRA) has determined that you no longer need home visits because of the following reason:

- ☐ You are employed outside the home.
- ☐ You submitted a written request for the removal of your HVN/HB status.
- ☐ Your temporary approval of HVN/HB status has expired and you did not submit new medical documentation to extend your status.
- ☐ Other (explain): _____

Removing your HVN/HB status means that a representative from HRA will no longer visit you at home and you may have to report to your Center for in-person appointments.

FIA-1028e (S) 03/07/2014
LLF

NYC Human Resources Administration Department of Social Services | Family Independence Administration

Fecha: _____

Número de Caso: _____

Nombre del Caso: _____

Número del Centro: _____

Núm. de Teléfono del Centro: _____

Aviso de Retiro del Estado de Necesidad de Visitas/Confinamiento al Hogar

Mediante la presente le informamos que su Estado de Necesidad de Visitas/Confinamiento al Hogar (HVN/HB) será retirado a partir de los 20 dias civiles desde la fecha de este aviso.

La Administración de Recursos Humanos (HRA) ha determinado que usted ya no necesita visitas al hogar debido a la siguiente razón:

- ☐ Usted está empleado fuera del hogar
- ☐ Usted presentó un pedido por escrito para solicitar la eliminación de Estado de Necesidad de Visitas al Hogar (HVN/HB).
- ☐ Su aprobación temporaria de Estado de Necesidad de Visitas al Hogar (HVN/HB) ha vencido y usted no presentó documentación médica nueva para extender su Estado de Necesidad de Visitas al Hogar (HVN/HB).
- ☐ Otra razón, (explique): _____

Retirar su Estado de Necesidad de Visitas al Hogar (HVN/HB) significa que un representante de la HRA ya no lo visitará en su hogar y que usted tendrá que presentarse en persona a su Centro para las citas.

Human Resources Administration
Department of Social Services
Family Independence Administration

Date: _____

Case Number: _____

Case Name: _____

Center: _____

Center Telephone No.: _____

Notice of Scheduled Home Visit

☐ We are sending this notice to inform you that an HRA representative will visit your home, as confirmed by our telephone conversation with you on: _____.
Your home visit appointment is scheduled for:

Appointment Date: _____ Time: _____ ☐ AM ☐ PM

If you are not able to keep this appointment, please call your Center immediately at _____

☐ We are sending this notice to inform you that an HRA representative has been unable to reach you via telephone to schedule a home visit. Please call your Center at: _____ within five business days of receiving this notice to let us know when a Worker can visit you at home.

The purpose of this home visit is to discuss:

☐ You must have the following documentation available during the home visit:

If you have any questions or are unable to keep this appointment, please call the telephone number above. You must contact us prior to the time scheduled for your home visit.

☐ **This is a mandatory eligibility appointment.** Failure to keep this appointment or contact us may make you ineligible for or result in a reduction in your Cash Assistance and/or Supplemental Nutrition Assistance Program (SNAP) benefits.

☐ **This is a nonmandatory eligibility appointment.**

☐ **This is not an eligibility appointment.**

NYC Human Resources Administration Department of Social Services | Family Independence Administration

Fecha: _____

Número del Caso: _____

Nombre del Caso: _____

Centro: _____

Número de Teléfono del Centro: _____

Aviso de Visita Programada al Hogar

☐ Le estamos enviando este aviso para informarle que un representante de la Administración de Recursos Humanos (Human Resources Administration – HRA) visitará su hogar, según confirmamos en nuestra conversación telefónica el: _____. Su cita de visita al hogar está programada para el:

Fecha de la Cita: _____ Hora: _____ ☐ AM ☐ PM

Si no puede cumplir esta cita, por favor llame a su Centro inmediatamente al: _____

☐ Le estamos enviando este aviso para informarle que un representante de la Administración de Recursos Humanos (Human Resources Administration – HRA) no pudo comunicarse con usted por teléfono para programar una visita al hogar. Por favor llame a su Centro al: _____ dentro de los cinco días laborales de haber recibido este aviso para informarnos cuándo un Trabajador puede visitar su hogar.

El objetivo de esta visita al hogar es discutir sobre:

☐ Usted debe tener la siguiente documentación disponible durante la visita al hogar:

Si usted tiene alguna pregunta o si no puede cumplir esta cita, favor de llamar al número de teléfono indicado arriba. Usted debe comunicarse con nosotros antes de la hora de su cita programada de visita al hogar.

☐ **Esta cita de elegibilidad es obligatoria.** El incumplimiento de esta cita o la falta de comunicación con nosotros puede resultar en su inelegibilidad para Asistencia en Efectivo o en una reducción de dicha asistencia y/o de beneficios del Programa de Asistencia de Nutrición Suplementaria (SNAP).

☐ **Esta cita de elegibilidad no es obligatoria.**

☐ **Esta cita no es de elegibilidad.**

FIA-1028i (E) 01/24/2013
LLF

Human Resources Administration
Department of Social Services
Family Independence Administration

Date: _____

Case Number: _____

Case Name: _____

Center: _____

Telephone Number: _____

Documentation Request for
Home Visits Needed/Homebound Requests

To support your request for Home Visit Needed/Homebound (HVN/HB) status, please provide the documentation indicated by the date listed below.. We have enclose a return envelope in which to mail the documentation.

Due Date: _____

Needed Documentation:

☐ HIPAA Authorization for the Disclosure of Individual Health Information Form (**HRA-108**)
Note: HRA-108 is only needed if you are requesting HRA's assistance to obtain medical documentation.

☐ Activities of Daily Living–Client Information Form (**CAS-102**)

☐ Home Visit Needed Request Clinician Assessment Form (**CAS-103**) signed by your medical provider **OR** signed current medical documentation on a clinician's letterhead.

Documents may be mailed to:

Job Center:
Attn: HVN/HB Request

Address: _____

_____

City: _____ State: _____ Zip: _____

Telephone: _____

If you are unable to provide the documentation requested by the due date listed above or if you need assistance obtaining medical documentation, please call the telephone number listed above.

If HRA does not receive completed and signed medical documents by the due date listed above, your request for HVN/HB status may be denied.

NYC Human Resources Administration Department of Social Services | Family Independence Administration

Fecha: _____

Número del Caso: _____

Nombre del Caso: _____

Centro: _____

Número de Teléfono: _____

Petición de Documentación para Estado de Necesidad de Vista al Hogar/Confinamiento al Hogar

Para justificar su petición de estado de Necesidad de Visita al Hogar/Confinamiento al Hogar (HVN/HB), favor de proporcionar la documentación indicada para le fecha listada más abajo. Hemos adjuntado un sobre de vuelta para el envío de la documentación.

Fecha de Entrega: _____

Documentación Pendiente:

☐ Formulario de Autorización HIPAA para la Divulgación de Información Médica Personal (**HRA-108 [S]**)
Nota: HRA-108 [S] sólo se necesita si usted está solicitando la asistencia de HRA para obtener documentación médica.

☐ Formulario de Actividades de la Vida Diaria–Información del Cliente (**CAS-102 [S]**)

☐ Home Visit Needed Request Clinician Assessment Form (Formulario de Necesidad de Visita al Hogar y Petición de Evaluación Clínica) (**CAS-103**) firmado por su proveedor médico **O** documentación médica firmada en membrete de médico clínico.

La documentación se puede enviar por correo a:

Centro de Trabajo:
Attn: HVN/HB Request

Dirección: _____

_____

Ciudad: _____ Estado: ____ Código Postal: _____

Teléfono: _____

Si usted no puede proporcionar la documentación solicitada para la fecha de entrega listada arriba o si necesita ayuda en obtener documentación médica, favor de llamar al número de teléfono listado arriba.

Si la HRA no recibe los documentos médicos llenados y firmados para la fecha de entrega listada arriba, su petición de estado de HVN/HB puede ser rechazada.

NYC Human Resources Administration Department of Social Services | Family Independence Administration

Date: _____

Case Number: _____

Case Name: _____

Center: _____

Notification of Expiration of Home Visit Needed/Homebound Status

Our records show that your Home Visit Needed/Homebound (HVN/HB) status will expire in approximately 30 days from the date of this notice. If you feel that you still need HVN/HB status, please mail us new and updated medical documentation to support your claim.

In order for the Human Resources Administration (HRA) to make a determination about your continued need for HVN/HB status, before your HVN/HB status expires, please provide the new, updated, completed and signed medical documentation by the due date listed below. We have enclosed a return envelope in which to mail the documentation.

Due Date: _____.

Documentation:

- ☐ HIPAA Authorization for the Disclosure of Individual Health Information Form (**HRA-108 [E]**)
  Note: **HRA-108 (E)** is only needed if you are requesting HRA's assistance to obtain medical documentation.
- ☐ Home Visit Needed Request Clinician Assessment Form (**CAS-103**) signed by your medical provider **or** signed current medical documentation on a doctor's letterhead.

Please contact us immediately at the telephone number listed below if you are unable to return the documents by the due date or if you need assistance in obtaining medical documentation.

If HRA does not receive new updated, completed and signed medical documentation by the due date listed above, your HVN/HB status will expire and you will be required to attend in office appointments.

You may contact us for assistance at: _____

Please mail documents to:

Location Name: _____

Address: _____

_____

City: _____ State: _____ Zip: _____

NYC Human Resources Administration Department of Social Services | Family Independence Administration

Fecha: _____

Número del Caso: _____

Nombre del Caso: _____

Centro: _____

Notificación del Vencimiento de Estado de Necesidad de Visitas/Confinamiento al Hogar

Según nuestros archivos su estado de Necesidad de Visitas/Confinamiento al Hogar (HVN/HB) se vencerá en aproximadamente 30 días de la fecha de este aviso. Si usted cree que aún necesita el estado de HVN/HB, favor de enviarnos por correo la documentación médica nueva y actualizada para justificar su necesidad.

Para que la Administración de Recursos Humanos (HRA) pueda determinar su necesidad continua de estado de HVN/HB, antes de que su estado de HVN/HB se venza, favor de proporcionar la documentación médica nueva, actualizada, llenada y firmada para la fecha de entrega listada más abajo. Hemos adjuntado un sobre de vuelta para enviar por correo la documentación.

Fecha de Entrega: _____.

Documentación:

- ☐ Formulario de Autorización HIPAA para la Divulgación de Información Médica Personal **(HRA-108 [S])** **Nota**: El **HRA-108 (S)** sólo se necesita si usted está solicitando la ayuda de la HRA para obtener la documentación médica.
- ☐ Formulario de Petición de Evaluación por Médico Para Necesidad de Visitas al Hogar **(CAS-103)** (Home Visit Needed Request Clinician Assessment Form) firmado por su proveedor médico **o** documentación médica actual firmada en el membrete de médico.

Favor de comunicarse con nosotros de inmediato al número de teléfono listado más abajo si usted no puede devolver los documentos para la fecha de entrega o si necesita ayuda para obtener la documentación médica.

Si la HRA no recibe la documentación médica nueva y actualizada, llenada y firmada para la fecha de entrega listada más arriba, su estado de HVN/HB se vencerá y a usted se le exigirá que se presente a citas en determinadas oficinas.

Si necesita ayuda usted puede comunicarse con nosotros al: _____

Favor de enviar por correo la documentación a:

Nombre del Local: _____

Dirección: _____

_____

Ciudad: _____ Estado: _____ Código Postal: _____

NYC Human Resources Administration Department of Social Services | Family Independence Administration

Center Name: _____

Applicant/Participant Name: _____

Case Number: _____

Applicant Registration Number: _____

HVN/HB Status Liaison Name: _____

HVN/HB Liaison Telephone Number: _____

Home Visit Needed (HVN)/Homebound (HB) Status Liaison Checklist of Documents for CAS Review

- ☐ A signed and completed HIPAA Authorization for the Disclosure of Individual Health Information Form (**HRA-108**). (If the individual refused to sign **HRA-108**, "Refused to Sign" should be written across the document.). **NOTE**: A completed **HRA-108** is only required when an individual is requesting HRA's assistance to obtain medical documentation.
- ☐ A signed and completed Activities of Daily Living Client Information Form (**CAS-102**).
- ☐ Medical documentation (Check the box below that applies):
  - ☐ A signed and completed Home Visit Needed Request Clinician Assessment Form (**CAS-103**).
  - ☐ Other signed medical documentation on the medical provider's letterhead.
  - ☐ The individual indicated on the **CAS-102** that they have submitted a supportive housing application (**HRA-2010e**) within the past twelve months or have completed a WeCARE medical assessment within the past twelve months.

Make sure you have checked the relevant boxes on this form. Attach this form to your email to CAS.

Human Resources Administration
Department of Social Services
Family Independence Administration

Date: _____

Case Number: _____

Case Name: _____

Center: _____

Missed Homebound Assessment Interview

We have attempted to visit you on _____ but were unable to enter your building or reach you by telephone. It is urgent that you contact the Job Center in reference to your request for a Home Visit Needed/Homebound (HVN/HB) interview for Cash Assistance (CA).

As soon as you receive this letter, please call _____

at _____, Monday through Friday between the hours of 9:00 AM and 5:00 PM.

Failure to contact us may result in a denial of your Home Visit Needed/Homebound status request.

Thank you for your cooperation.

NYC Human Resources Administration Department of Social Services | Family Independence Administration

Fecha: _____

Número del Caso: _____

Nombre del Caso: _____

Centro: _____

Incumplimiento de Entrevista de Evaluación de Confinamiento al Hogar

Nosotros hemos intentado visitarle el _____ pero no pudimos entrar a su edificio o comunicarnos con usted por teléfono. Es urgente que usted se comunique con el Centro de Trabajo respecto a su petición de una cita de Necesidad de Visita/Confinamiento (HVN/HB) al Hogar para Asistencia en Efectivo (CA).

Tan pronto usted reciba esta carta, favor de llamar a _____

al _____, de lunes a viernes entre las 9:00 AM y las 5:00 PM.

La falta de comunicación con nosotros puede resultar en la denegación de su petición del estado de Necesidad de Visita/Confinamiento al Hogar.

Gracias por su cooperación.

Human Resources Administration
Department of Social Services
Customized Assistance Services

CAS-102 (E) 08/29/12

Home Visit Needed Request
Activities of Daily Living – Client Information Form

To assist the New York City Human Resources Administration (HRA) in determining your ability to travel and attend required appointments, please complete and sign this form and provide copies of any medical records that would help in making this determination.

Name: _____ **Case Number (if applicable)**: _____ **SSN**: _____

Date of Birth: _____ **Gender**: _____ **Phone**: _____

Address: _____

Do you have any clinical conditions? ☐ Yes ☐ No **If yes, list:**

_____
_____
_____
_____
_____
_____

Are you taking any medication? ☐ Yes ☐ No **If yes, list:**

_____
_____
_____

Do you have a doctor? ☐ Yes ☐ No **If yes:**

Doctor's Name: _____ **Phone**: _____

Address: _____

How do you get to your doctors' appointments?

_____

Are you able to go to a WeCARE site for a medical assessment, if we give you a referral? ☐ Yes ☐ No

Do any of your medical and/or mental health conditions make it hard for you to:

1. **Travel to appointments** ☐ Yes ☐ No
2. **Take public transportation?** ☐ Yes ☐ No
3. **Travel outside of the home without a companion?** ☐ Yes ☐ No
4. **Attend medical or other appointments?** ☐ Yes ☐ No
5. **Go food shopping or handle other routine errands?** ☐ Yes ☐ No

If yes to any of the above, explain:

_____
_____
_____

Do you have a home attendant or other home care services? ☐ Yes ☐ No **Daily hours of home care** _____

Do you have someone who can escort you to appointments or run errands for you? ☐ Yes ☐ No

Do you have an application pending with the Social Security Administration for federal disability benefits (SSI or SSDI)? ☐ Yes ☐ No

Has an application for supportive housing (HRA 2010e) been submitted to HRA for you within the past year? ☐ Yes ☐ No

Have you completed a WeCARE medical assessment within the past year? ☐ Yes ☐ No

I certify that the statements above are accurate and true to the best of my knowledge.

Signature: _____ **Date**: _____

Human Resources Administration
Department of Social Services

Customized Assistance Services

CAS-103 (E) 09/30/2011

Home Visit Needed Request
Clinician Assessment Form

THIS SECTION TO BE COMPLETED BY HRA

Client's Name: _____ **Date of Birth**: _____ **SSN**: _____

Address: _____ **Gender**: _____

HRA Address: _____
(Send copies of all substantiating medical reports and progress notes to the above address)

THIS SECTION MUST BE COMPLETED BY A PHYSICIAN, NURSE PRACTITIONER OR PHYSICIAN'S ASSISTANT: To assist the New York City Human Resources Administration (HRA) to determine your patient's ability to travel to and attend HRA required appointments, please complete and sign this form and provide copies of any medical records that would be relevant to making this determination.

Date of Client's Last Medical Visit: _____

Current Clinical Conditions:

_____
_____
_____
_____

Current Medications:

_____
_____
_____

Do any of the above conditions affect the client's ability to:

1. **Travel to appointments** ☐ **Yes** ☐ **No**
2. **Take public transportation?** ☐ **Yes** ☐ **No**
3. **Travel outside of the home without a companion?** ☐ **Yes** ☐ **No**
4. **Attend medical or other appointments?** ☐ **Yes** ☐ **No**
5. **Go food shopping or handle other routine errands?** ☐ **Yes** ☐ **No**

If you answered 'Yes' to any of the above:

1. **Explain how the condition affects the client's ability to travel to and/or participate in HRA appointments**:

   _____
   _____
   _____

2. **Is the travel limitation temporary?** ☐ **Yes** ☐ **No**

   a. **If 'Yes', estimate date condition will improve and client will be able to travel**. _____

Clinician's Name (please print): _____

Title: _____ License Number: _____

Clinician's Signature: _____ Date: _____

Address: _____

_____ Tel. Number: _____

CAS-300 (E) 06/23/2011

Human Resources Administration
Department of Social Services
Customized Assistance Services

Date:
Case Number:
Case Name:
Case Type:
Center:
Action Code:

Medical Provider Appointment
Wellness, Comprehensive Assessment, Rehabilitation and Employment (WeCARE)
Referral for Assessment

You have requested Home Visit Needed (HVN) status and have agreed to go to WeCARE for a medical assessment. The purpose of this appointment is to assess your request for HVN status, by assessing your ability to travel to and participate in HRA related appointments. If you miss this appointment, your request for HVN status may be denied.

Your appointment with WeCARE is indicated below:

Appointment Date: **Time:** **Telephone:**
Location Name:
Address:
City: **State:** **Zip Code:**

Travel Directions:

The goal of the medical assessment is to identify medical problems and evaluate your request for HVN status by assessing your ability to travel to and participate in HRA related appointments. If needed, the medical provider will work with you to develop a plan to restore you to the best possible level of health and self-sufficiency. Please be aware that the assessment may take four (4) hours or longer.

If you cannot keep the medical provider appointment or need special accommodations, please call the phone number listed above for assistance before your scheduled appointment time.

Please bring this letter, your photo ID, Medicaid card and Social Security Card, if available. You should also bring any recent doctor's letter, medical documentation, prescriptions or other forms that may provide information on your medical condition.

You may have someone accompany you to this appointment if you require assistance. All HRA medical provider facilities are accessible for individuals with disabilities.

If you do not report to HRA's medical provider within one (1) hour of your appointment, you may not be seen.

CAS-311 (E) 10/03/2011

Human Resources Administration
Department of Social Services
Customized Assistance Services

Date:
Case Number:
Case Name:
Case Type:
Center:
Action Code:

Home Visit Needed
Wellness, Comprehensive Assessment, Rehabilitation and Employment (WeCARE)
Assessment Cancellation

You have asked to cancel your voluntary WeCARE appointment to assess your request for Home Visit Needed (HVN) status. Please provide medical documentation in order to support your request for HVN status. Please have your doctor complete the attached *Home Visit Needed Request Clinician Assessment Form* (*CAS-103*) or submit signed current medical documentation on a clinician's letterhead that supports your request for HVN status. All documentation should be sent to the FIA Job Center address listed below and must be received no later than the date posted below. Please note that if you do not provide documentation supporting your request for HVN status, your request may be denied.

Medical Documentation must be received by:

Date:

Send Medical Documentation to the address listed below:

Job Center:
Attn: HVN/HB Request
Address:
City: **State:** **Zip Code:**
Telephone:

If you are unable to provide the documentation requested by the due date listed above or if you need assistance obtaining medical documentation, please call the telephone number listed above.

Human Resources Administration
Department of Social Services

Request for an Appeal of a Reasonable Accommodation Determination

INSTRUCTIONS:
Complete and submit this form within twenty (20) calendar days from the date on the determination form(s) to:

ADA Compliance Unit
180 Water Street, 17th Floor
New York, New York 10038
Fax: (917) 639-0333
E-mail: adaola@hra.nyc.gov

Appeals should be submitted in writing. You may attach any supporting medical documentation to this form. Individuals who cannot complete written forms due to physical and/or mental condition(s) may contact the Office of Constituent Services (OCS) for assistance at **(212) 331-4640**.

Section I – HRA Client Information:

Name (*Please Print Clearly*): _____ Case Number (*If Known*): _____
Social Security Number (*If Known*): _____ Telephone Number: _____

Mailing Address: _____

HRA Program/Service (*If Known*): _____ Center No. (*If Known*): _____

Section II – Reasonable Accommodation(s) You Wish to Appeal:

You may use this form to appeal more than one determination.

1) Please describe the reasonable accommodation(s) that were denied and the date of denial. (You may attach additional sheets, if necessary.)

_____
_____
_____
_____

2) Please tell us why you think HRA's decision was wrong: _____

_____
_____
_____
_____

3) Were you offered an alternative accommodation? If so, explain here:

_____
_____

If you were offered an alternative accommodation, please indicate by checking the appropriate box below, whether you will accept that alternative accommodation.

☐ Yes, I will accept the alternative accommodation.

☐ No, I will not accept the alternative accommodation. Please explain why: _____

_____

HRA Applicant/Participant Signature: _____ Date: _____

-or-

Authorized Representative Signature: _____ Date: _____

Print Name: _____ Relationship to Applicant/Participant: _____

For internal use only: ☐ Completed by Office of Constituent Services: _____ Date: _____

Human Resources Administration
Department of Social Services

Petición de Apelación de la Determinación de Arreglo Razonable

INSTRUCCIONES:
Llene y presente este formulario dentro de veinte días (20) civiles de la fecha en el/los formulario(s) de determinación a:

ADA Compliance Unit
180 Water Street, 17th Floor
New York, New York 10038
Fax: (917) 639-0333
E-mail: adaola@hra.nyc.gov

Las apelaciones deben ser presentadas por escrito. Usted puede adjuntar cualquier documentación médica justificativa a este formulario. Las personas que no pueden llenar los formularios por escrito debido a un problema físico y/o mental pueden comunicarse con la Oficina de Servicios Constituyentes (OCS) para asistencia al **(212) 331-4640**.

Sección I – Información del Cliente de la HRA:

Nombre (*Favor de Usar Letra Molde)*: _____ Número del Caso (*De Saberlo*): _____
Número de Seguro Social (*De Saberlo*): _____ Número de Teléfono: _____

Dirección Postal: _____

Programa/Servicio de la HRA (*De Saberlo*): _____ Núm. del Centro (*De Saberlo*): _____

Sección II – Arreglo(s) Razonable(s) Que Usted Desea Apelar:

Usted puede usar este formulario para apelar más de una determinación.

1) Favor de describir el/los arreglo(s) razonable(s) que fue(ron) negado(s) y la fecha de la denegación. (Usted puede adjuntar hojas adicionales, si necesario.)

_____
_____
_____
_____

2) Favor de indicar la razón por la cual usted cree que la decisión de la HRA fue errónea: _____

_____
_____
_____
_____

3) ¿Le ofrecieron a usted un arreglo alternativo? En tal caso, explique aquí:

_____
_____

Si a usted se le ofreció un arreglo alternativo, favor de indicar, marcando la casilla apropiada más abajo, si usted aceptará el arreglo alternativo.

☐ Sí, yo aceptaré el arreglo alternativo.

☐ No, yo no aceptaré el arreglo alternativo. Favor de explicar por qué no: _____

_____

Firma del Solicitante/Participante de HRA: _____ Fecha: _____

-o-

Firma del Representante Autorizado: _____ Fecha: _____

Nombre en Letra de Molde: _____ Relación con el Solicitante/Participante: _____

For internal use only: ☐ Completed by Office of Constituent Services: _____ Date: _____

Human Resources Administration
Department of Social Services

HIPAA AUTHORIZATION FOR THE DISCLOSURE OF INDIVIDUAL HEALTH INFORMATION

Patient Name:		**Social Security Number:**	
Patient Address:		**Date of Birth:**	

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 Article 27-F of the New York State Public Health Law, the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), and 42 U.S.C. § 290dd-2 and its implementing regulations at 42 C.F.R. Part 2, 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 10(b). 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 10(b), I specifically authorize release of such information indicated in Item 10(b) to the NYC Human Resources Administration (HRA).
2. In the event that HRA determines that I am potentially eligible for federal disability benefits, I authorize HRA to release my medical and/or mental health treatment information, which may include confidential HIV related information and/or alcohol or drug treatment records to the Social Security Administration (SSA) for its review of my eligibility for federal disability benefits.
3. 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) 961-8650** or the New York City Commission of Human Rights at **(212) 306-7450**. These agencies are responsible for protecting my rights.
4. I understand that signing this authorization is voluntary. My treatment, payment to treatment providers, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure. However, if I do not authorize HRA to share my medical information with SSA, this may result in a discontinuance of my Cash Assistance (CA) benefits.
5. I understand that I may revoke this authorization except to the extent that HRA and my medical provider have already acted upon it. I may revoke this authorization at any time by writing to the health care provider at the address specified below and to HRA at: **NYC Human Resources Administration, Office of Constituent Services, 180 Water Street, 23rd Floor, New York, NY 10038**
6. Authorized recipients of my medical information may, in certain instances, have the right to redisclose my medical documentation without the need to obtain additional written consent from me. I understand that such redisclosures may no longer be protected by federal or state law.
7. **This authorization does not authorize my medical provider to discuss my health information or medical case with anyone other than the NYC Human Resources Administration as specified in item 10(b)**.

AUTHORIZATION TO DISCUSS HEALTH INFORMATION

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

_____

9. Name and address of agency to whom this information will be sent: **NYC Human Resources Administration, Customized Assistance Services, Office of Reasonable Accommodations, 2 Washington Street, 17th floor, New York, NY 10004**

10(a). Specific information to be released: **Medical records for the entire year prior to the signature date below.**
Include (*Indicate by Initialing*):

☐ Alcohol/Drug Treatment ☐ Mental Health Information ☐ HIV Related Information

10(b). By initialing here _____, I authorize _____
(Initials) (Name of individual health care provider)
to discuss my health information with the **NYC Human Resources Administration**.

11. Reason for release of information: **At request of patient**
12. Date or event on which this authorization will expire: **One year from the date of signature**
13. If not the patient, name of person signing form: _____
14. 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 with a copy of the form.

_____ _____
Signature of Patient or Authorized Representative by Law Date

***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.**

Human Resources Administration
Department of Social Services

HRA-108 (S) 10/18/2012 LLF

AUTORIZACIÓN HIPAA PARA LA DIVULGACIÓN DE INFORMACIÓN MÉDICA PERSONAL

Nombre del Paciente:		**Número de Seguro Social:**	
Dirección del Paciente:		**Fecha de Nacimiento:**	

Yo, o mi representante autorizado, solicito(a) que información médica respecto a mi cuidado y tratamiento sea divulgada tal como se estipula en el presente formulario. Conforme al Artículo 27-F de la Ley del Estado de Nueva York de Salud Pública (New York State Public Health Law), la Regla de Intimidad de la Ley de 1996 de Portabilidad y Responsabilidad de Seguro Médico (Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 – HIPAA), y 42 U.S.C. § 290dd-2 y sus reglas de aplicación en 42 C.F.R. Part 2, entiendo que:

1. Esta autorización puede incluir divulgación de información relacionada con **ALCOHOL** y **DROGADICCIÓN, TRATAMIENTO PSIQUIÁTRICO**, excepto notas de psicoterapia e **INFORMACIÓN CONFIDENCIAL RELACIONADA CON VIH*** sólo si pongo mis iniciales en la línea indicada en el Artículo (Item) 10(b). Dado que la información médica definida más abajo incluya cualquier de estos tipos de datos, y de que la rúbrica con mis iniciales aparezca en la casilla en el Artículo (Item) 10(b), autorizo explícitamente la divulgación de tal información indicada en el Artículo (Item) 10(b) a la Administración de Recursos Humanos de la Ciudad de Nueva York (NYC HRA).
2. En caso de que la HRA determine que yo sea posiblemente elegible para beneficios federales por incapacidad, autorizo a la HRA para divulgar mis datos de tratamiento médico y/o psiquiátrico, lo que puede incluir información confidencial relacionada con VIH y/o expedientes de tratamiento para alcoholism o drogadicción a la Administración de Seguro Social (SSA) para su revisión de mi elegibilidad para beneficios federales por incapacidad.
3. Entiendo que yo tengo el derecho de solicitar una lista de las personas quienes pueden recibir o utilizar mis datos relacionados con VIH sin autorización. Si sufro discriminación debido a la divulgación de información relacionada con VIH, puedo comunicarme con la División del Estado de Nueva York de Derechos Humanos (New York State Division of Human Rights) al **(212) 961-8650** o con la Comisión de la Ciudad de Nueva York de Derechos Humanos (New York City Commission of Human Rights) al **(212) 306-7450**. Sobre estas agencias recae la responsabilidad de proteger mis derechos.
4. Entiendo que la firma de esta autorización es voluntaria. Ni mi tratamiento, pago a los proveedores de tratamiento, ni la inscripción en un plan médico, ni la elegibilidad para beneficios estarán sujetos a condiciones respecto a mi autorización de esta divulgación. No obstante, si yo no autorizo a la HRA para compartir mis datos médicos con la SSA, esto puede resultar en la discontinuación de mis beneficios de Asistencia en Efectivo (CA).
5. Entiendo que yo puedo cancelar esta autorización excepto en la medida que la HRA y mi proveedor médico la hayan anteriormente cumplido. Yo puedo cancelar esta autorización en cualquier momento mediante una carta al proveedor médico a la dirección especificada más abajo y a la HRA al: **NYC Human Resources Administration, Office of Constituent Services, 180 Water Street, 23rd Floor, New York, NY 10038**
6. Los destinatarios autorizados de mis datos médicos puede, en ciertas circunstancias, tener derecho a divulgar de nuevo mi documentación médica sin tener que obtener consentimiento adicional por escrito de parte mía. Entiendo que tal nueva divulgación puede carecer del amparo de la ley federal o estatal.
7. **Esta autorización no le concede a mi proveedor el derecho de tratar de mi información médica o mi caso médico con nadie excepto la Administración de Recursos Humanos de la Ciudad de Nueva York, como se estipula en el artículo (item) 10(b).**

AUTORIZACIÓN PARA TRATAR DE INFORMACIÓN MÉDICA

8. Nombre y dirección del proveedor médico o entidad para divulgar esta información: _____

_____

9. Nombre y dirección de la agencia a la cual esta información sera enviada: **NYC Human Resources Administration, Customized Assistance Services, Office of Reasonable Accommodations, 2 Washington Street, 17th floor, New York, NY 10004**

10(a). Información específica a ser divulgada: **Expedientes médicos para todo el año previo a la fecha de la firma más abajo.**
Incluya (*Indique con sus iniciales*):

☐ Tratamiento para Alcoholismo/ Drogadicción ☐ Información Psiquiátrica ☐ Información relacionada con VIH

10(b). Mediante mis iniciales aquí _____, autorizo a _____
(Iniciales) (Nombre del proveedor de cuidado médico)
a tratar de mi información médica con la **Administración de Recursos Humanos de la Cuidad de Nueva York**.

11. Razón por la divulgación de datos: **A petición del paciente**
12. Fecha o circunstancia en que esta autorización se vencerá: **Un año desde la fecha de la firma**
13. Aparte del paciente, nombre del firmante: _____
14. Autoridad para firmar a nombre del paciente: _____

Toda la información solicitada ha sido presentada en este formulario, y mis preguntas respecto a este formulario han sido contestadas. Además, se me ha proporcionado una copia del formulario.

_____ _____
Firma del Paciente o Representante Leglamente Responsible Fecha

***El Virus de Inmunodeficiencia Humana que causa el SIDA. La Ley de Nueva York de Salud Pública protege la información que dentro de lo razonable puede comprometer la identidad de una persona con síntomas o infección de VIH, al igual que la información referente a los contactos de dicha persona.**