REQUEST FOR MEDICAL INFORMATION

Applicant: Authorization to Release Information - Please sign below and have your medical provider complete the section below and return this sheet to the Minneapolis Public Housing Authority (MPHA) address noted.

I hereby give my permission to release to the MPHA the information requested below for the purpose of determining eligibility for admission to Low Rent Public Housing. This release shall be effective for a period of one year from the date noted below.

Name:_____ Address: _____

Signature: _____ Date: _____

Applicant's Medical Provider:
Complete the information listed below. It is required by MPHA to assist in determining eligibility/priority for public housing. Please respond within fifteen (15) days so the client's application can be processed in a timely manner. Thank you.

MINNEAPOLIS PUBLIC HOUSING AUTHORITY
Manager of Leasing and Occupancy

In order to process the above named individual's application for public housing, who is claiming a disability, **complete all of the requested information below**:

1. Please review the definitions below and indicate whether or not the applicant is disabled as defined in Section 223 of the Social Security Act, or Section 102 (b)(5) of the Developmental Services and Facilities Construction Amendment of 1970, or as defined in 24 CFR Section 812.2(e).

   A. Inability to engage in any substantial, gainful activity by reason of my medically determinable physical or mental impairment which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than 12 months. [ ]Yes [ ] No

   B. In the case of an individual who has attained an age of 55 and is blind (within the meaning of "Blindness" as defined in Section 416 (i)(I); inability by reason of such blindness to engage in substantial gainful activity requiring the skills or abilities comparable to those of any gainful activity in which he/she has previously engaged with some regularity and over a substantial period of time. [ ]Yes [ ] No

   C. A disability attributable to mental retardation, cerebral palsy, epilepsy or another neurological condition of an individual found by the Secretary of Health and Human Services to be closely related to mental retardation or to require treatment similar to that required for mentally retarded individuals, which has continued or can be expected to continue indefinitely, and which constitutes a substantial handicap to such an individual. [ ]Yes[ ]No

   D. A handicapped person is defined in 24 CFR Section 812.2 (e); a person having a physical or mental impairment which (1) is expected to be of long continued and indefinite duration, (2) substantially impedes his/her ability to live independently, and (3) is of such a nature that such a disability could be improved by more suitable housing conditions. [ ] Yes [ ] No

2. If you are unable to complete this form, please indicate the reason;
   a. I do not know the medical history of this person well enough to complete this form. _____
   b. I have not examined this person recently._____
   c. Other (Explain):_____

3. I certify that the information provided is in response to a direct and explicit request of this patient.

   Provider's Name: _____ State Certified by:_____

   Medical License Number:_____ Valid through (Year):_____

   Address:_____ Phone:_____

   Provider's Signature: _____ Date:_____

Return to: MPHA Leasing & Occupancy Department; 1001 Washington Ave. No., Minneapolis, MN 55401
Call (612) 342-1491 with questions. Fax this form to (612) 342-1396 Revised 3/2015