Housing Authority of the Cherokee Nation
109 13th St.
P.O. Box 328
Jay, OK 74346

Phone: 918-456-5482
Toll Free: 800-837-2869

Fax: 918-453-2959

HOUSING ACCESSIBILITY/MEDICAL DIAGNOSIS FORM

Applicant's Name Bobby HornBack

Applicant's Signature Bobby HornBack

Special considerations for housing rehab from Housing Authority of the Cherokee Nation are authorized for person(s) with a medical diagnosis of a physical condition or mental impairment which

(a) is expected to be of long-continued or indefinite duration (not less than 12 months)
(b) substantially impedes his/her ability to live independently and
(c) is in such a nature such ability could be improved by more suitable housing conditions.

Please provide the above applicant's medical diagnosis and limitations in detail in the space below: (Examples Patient will need, such as grab bars at Toilet, Shower, High rise toilet, walk in Shower, or Shower w/a transfer, Entry doors 35", Ramps, Hearing or Sight Impaired, or other).

Automatic Door Openers on Exterior Doors
These items are medically necessary for ability to function in the home
Individual has quadriplegia DT Spinal cord injury.
48" exterior doors with auto door openers
Zero Clearance in-floor shower - NO Curb flush with floor
5' wide hallway for power chair turn around and Turning
Track on ceiling for ceiling mounted lift
This negates the need for use of overhead lift which can cause harm for this individual

5/1/25
Date

Physician Signature

Address

Telephone Number

HOUSING AUTHORITY
OF THE CHEROKEE NATION
Keys to a brighter future

Housing Authority of the Cherokee Nation
1500 Hensley Drive
P.O. Box 1007
Tahlequah, OK 74465-1007

Phone 918-456-5482
Toll Free 800-837-2869

Verification of Comorbidity for COVID-19

Complete the top half of this form by listing the name, address & telephone number of your medical provider. Also print your name and social security number.

Name of Medical Provider

Bobby Hornback
Print Applicant Name

Mailing Address

Social Security Number

City, State, and Zip Code

918 542 3335
Medical Provider's Phone Number

I hereby authorize you to furnish all of the information requested on this inquiry.

Bobby Hornback
Signature of Applicant/Tenant

5-1-25
Date

To Be Completed by the Medical Provider

The person listed above has applied for assistance from the Housing Authority of the Cherokee Nation (HACN). The assistance requested is under a program that requires the HACN to verify this person's eligibility. We ask your cooperation in providing the following information. The applicant has consented to this release of information as shown above. The most current info to answer the below question can be found at: www.cdc.gov/coronavirus

Information Being Requested

Please check the applicable answer that accurately describes the person.

1. _____ Yes
   _____ No

Has a certain underlying medical condition(s) as indicated by the CDC, as of the date of this form, as placing the individual at an increased risk of severe illness from COVID-19. The condition(s) may be exacerbated by conditions such as substandard living conditions or other environmental factors that may be present in their existing home.

Name & Title of Person Supplying Information

Firm/Organization

Signature

Date

CHEROKEE NATION HEALTH SERVICES
AUTHORIZATION TO USE OR SHARE PROTECTED HEALTH INFORMATION (PHI)

Patient Name: Bobby HornBack Medical/Client Record #: _____

Date of Birth: _____ Social Security #: _____

I hereby authorize the use and disclosure of health information about me as described below:

Authorize to Release: **Cherokee Nation Health Services**
Name & Address of Person/Organization Disclosing PHI

Authorize to Receive: **Cherokee Nation Housing Authority**
Name & Address/Organization Receiving PHI

Type of Records Authorized to Release: (Check all that apply)

☐ Medical ☐ Billing ☐ EMS ☐ Dental ☐ Mental Health ☐ Optometry

☐ Substance Abuse Record (SAR) List specific SAR Requested: _____

☐Psychotherapy Notes (if checking this box, no other boxes may be checked)

Records from **(insert date)** _____ to **(insert date)** _____

☒ Other: **Verification of Comorbidity of COVID-19** ☐ Entire Medical Record birth to present

Method by which information is to be released: ☐ Mail ☐ Electronic (CD) ☐ Other: _____

☒ Email Address: _____

I authorize my PHI to be used or disclosed for the following purpose(s) only:

☐ Insurance ☐ Legal ☒ At my or my representative's request ☐ Other: _____

I understand that by voluntarily signing this authorization:

- I have the right to receive a copy of this authorization.
- I understand that I may change this authorization at any time by writing to ***Cherokee Nation Health Services***.
- I have the right to withdraw permission for the release of my information. If I sign this authorization to use or disclose information, I can revoke this authorization at any time. The revocation must be made in writing to ***Cherokee Nation Health Services*** and will not affect information that has already been used or disclosed.
- I understand that I cannot restrict information that may have already been shared based on this authorization.
- I understand that unless the purpose of this authorization is to determine payment of a claim for benefits, signing this authorization will not affect my eligibility for benefits, treatment, enrollment or payment of claims.
- I understand that information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient and no longer protected by the Privacy Regulation.
- I understand that my medical information may indicate that I have a communicable and/or non-communicable disease, which may include, but not limited to diseases such as hepatitis, syphilis, gonorrhea or HIV or AIDS and/or may indicate that I have or have been treated for psychological or psychiatric condition or substance abuse. By signing below, I specifically authorize any such records included in my health information to be released.

This information has been disclosed to you from records protected by federal confidentiality rules (42 CFR Part 2). The federal rule prohibits you from making any further disclosure of information in this record that identifies a patient as having or having had a substance use disorder either directly, by reference to publicly available information, or through verification of such identification by another person unless further disclosure is expressly permitted by written consent of the individual whose information is being disclosed or as otherwise permitted by 42 CFR part 2. The federal rules restrict any use of the information to criminally investigate or prosecute with regard to a crime any patient with a substance abuse disorder.

Unless revoked or otherwise indicated, this authorization's automatic expiration date will be one year from the date of my signature or upon the occurrence of the following event _____.

Bobby HornBack — Signature of Patient or Legal Representative

5-1-25 — Date

_____ — Description of Legal Representative's Authority

_____ — Expiration Date (if longer than one year from date of signature or no event is indicated)