Exhibit 4

NYC Department of Homeless Services
Department of Social Services

COVID PLACEMENT REQUEST

Clinician Assessment Form

THIS SECTION TO BE COMPLETED BY HRA			
Client's Name:	Date of Birth:	Gender:	Social Security Number:
Address:			

THE FOLLOWING SECTIONS MUST BE COMPLETED BY A QUALIFIED, LICENSED HEALTHCARE PROVIDER

Your patient has submitted a request to the New York City Department of Homeless Services (DHS) for a reasonable accommodation. To assist DHS in determining your patient's need for a reasonable accommodation, please complete and sign this form and provide copies of any medical records that would be relevant in making this decision. **Please write clearly.**

PLEASE ANSWER THE FOLLOWING	
When was the date of the client's last visit?	How frequently does the client have appointments?
Was the client hospitalized recently? (Check one) ☐ YES ☐ NO	If YES, what was the date and length of stay?
Was the client have Home Care Services? (Check one) ☐ YES ☐ NO	If YES, how many hours/days?

PLEASE LIST THE FOLLOWING

Medical and/ or Psychiatric Diagnoses and Date of Onset: _____

Current Medications: _____

Durable Medical Equipment (if applicable): _____

Types and Frequency of Treatments: _____

Is the client a smoker? _____

Does the client have Down syndrome? _____

(Turn Page)

Department of Social Services
Department of Homeless Services

COVID PLACEMENT REQUEST

Clinician Assessment Form *(continued)*

Client's Name:	Date of Birth:	Social Security Number:

CHRONIC MEDICAL CONDITIONS | Please indicate severity of applicable conditions below:	
Cancer (in treatment)	If yes, specify cancer and treatment: _____ Is it in remission or cured? _____
Chronic kidney disease	If yes, specify: _____
Chronic lung disease	If yes, specify: _____ If COPD, what stage? _____
Heart disease	If yes, specify: _____
Sickle cell disease	If yes, specify: _____
Type 2 Diabetes	If yes, specify: _____ Is client on medication, if so, is client adherent to medication regimen? Elevated HbA1c? With Complications? _____ _____
Type 1 Diabetes	If yes, specify: _____ With severe complications? _____
Moderate to Severe Asthma	If yes, specify: _____
Severe Asthma	If yes, specify: _____
Cerebrovascular disease	If yes, specify: _____ Recent stroke? _____
Cystic Fibrosis	If yes, specify: _____
Pulmonary Fibrosis	If yes, specify: _____

(Turn Page)

Department of Social Services
Department of Homeless Services

COVID PLACEMENT REQUEST

Clinician Assessment Form *(continued)*

Client's Name:	Date of Birth:	Social Security Number:

CHRONIC MEDICAL CONDITIONS | Please indicate severity of applicable conditions below *(continued)*:	
Hypertension	If yes, specify: _____ Uncontrolled or untreated? _____
HIV (CD4 < 200)	If yes, specify: _____
Liver disease	If yes, specify: _____ Advanced cirrhosis or transplant candidate? _____
Thalassemia	If yes, specify: _____
BMI > 30	If yes, specify: _____
Neurological conditions (e.g., dementia)	If yes, specify: _____
Thalassemia or other hemoglobin disorders	If yes, specify: _____

IS THERE ANY OTHER INFORMATION YOU'D LIKE US TO KNOW ABOUT THE CLIENT?
_____ _____ _____ _____ _____

PLEASE COMPLETE THE FOLLOWING OR STAMP AND SIGN | THIS FORM IS INVALID WITHOUT SIGNATURE	
Clinician's Name (Please print):	
Specialty:	License Number:
Address:	Telephone Number:
Clinician's Signature:	Date: