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**Confirming your disability**

**Phone:** 0800 758 700 or 0508 447 6275

**Email:** [referrals@yourwaykiaroha.nz](mailto:referrals@yourwaykiaroha.nz)

**Who should use this form?**

If it is the first time you’ve worked with Your Way I Kia Roha Connections & Funding team, please ask your doctor or specialist to complete this form to confirm your disability. Please attach it to your Connections & Funding Referral Form. If you have any questions, please contact us using the details at the top of this form.

1. **Person’s Name and Diagnosis**

|  |  |
| --- | --- |
| Full name: | National Health Index Number (NHI): |
| Disability diagnosis: | |
| Is your / the person’s disability ACC related? Please tick  Yes  No  Does the person live with any other medical, mental health or accident-related conditions? If so, please describe: | |

1. **Health Professional Declaration**

|  |  |
| --- | --- |
| Full name: | Organisation: |
| Signature:  Date: | |