****

**Confirming your disability**

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

**Email:** 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:  |