County of San Diego
HEALTH AND HUMAN SERVICES AGENCY
HOUSING AND COMMUNITY DEVELOPMENT SERVICES
3989 RUFFIN ROAD, SAN DIEGO, CA 92123
(858) 694-4801 • FAX (858) 467-9713

CERTIFICATION OF NEED FOR LIVE-IN AIDE

DATE

Patient Name: _____ Patient's Age: _____

Dear State of California licensed medical or social service professional:

The above named patient has been approved for participation in the Section 8 Rental Assistance program and has reported to us that because of the nature of his/her disability, a live-in aide is required. A live-in aide is defined as a person who has been determined to be essential to the care and well-being of your patient. To help us make a determination, we would appreciate your evaluation based on your knowledge of the unique needs of your patient.

1. Is it your opinion that because of the nature of your patient's disability he/she requires the assistance of a live-in aide?
   [ ] YES [ ] NO

2. If you answered "Yes" above, please give us an idea how long the need will last.

   [ ] TEMPORARY (less than 12 months)
   If temporary, what is approximate duration?_____
   [ ] PERMANENT (more than 12 months)

3. Please explain why a live-in aide is necessary to provide this vital care to the patient that cannot be performed any other way (e.g., by day caregiver, other family member, etc.): Do Not List Diseases.

   _____

   _____

   _____

4. What are the hours the care must be provided? From_____to_____each day.

Thank you for your cooperation on behalf of your patient. If **this form is not answered completely or answers are not legible the request will be denied.**

I certify that it is my firm ***professional opinion*** that the above-named party has a serious medical condition that indicates a ***direct and verifiable*** need for bedroom live- in aide I further certify my professional opinion is in compliance with all applicable laws, regulations, standard industry practices and licensing guidelines. (Please print the information below.)

Professional's Name:_____ Professional's License No: _____

Address:_____ Phone No.:_____
Street City State Zip Code

Professional's Signature:_____ Date:_____

Please Return This Form to: FAX: File Name:

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