HEALTH CARE PROFESSIONAL’S CERTIFICATION OF NEED FOR HIGHER PAYMENT STANDARD

Patient Name: ____________________________ Date: __________________

Dear Health Care Professional:

Your 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, he/she must rent a higher-rent unit that accommodates his/her specific needs. 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 a unit with specific features that accommodate her disability?
   [ ] 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 how this unit will accommodate your patient’s disability:
   __________________________________________________________________________________
   __________________________________________________________________________________

4. Please explain why it will be essential to his/her well-being (Do not list symptoms or diseases):
   __________________________________________________________________________________
   __________________________________________________________________________________

Thank you for your cooperation on behalf of your patient. If the questions are not answered completely or legibly 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 additional federal funds for a higher payment standard. 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.: ______________

Professional’s Signature: _________________________________________ Date: _______________

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