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

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.: ______________

Street **City** **State** **Zip Code**

Professional's Signature: ____ Date: _______________