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 PROVIDER'S CERTIFICATION OF NEED FOR EXTRA BEDROOM

SECTION 1: PATIENT'S INFORMATION

Patient Name: _____ Patient's DOB: _____

Patient's Age: _____

SECTION 2: HUD DEFINITION OF DISABILITY

DEFINITION OF DISABILITY: Section 504 of the Rehabilitation Act of 1973 and Fair Housing Amendments define a "disability" as:

- A physical or mental impairment that substantially limits one or more major life activities;
- A record of such impairment; or
- Being regarded as having such an impairment.

SECTION 3: HEALTHCARE PROFESSIONAL'S CERTIFICATION OF NEED FOR ACCOMMODATION

Dear State of California licensed medical or social service professionals:

The above-named patient has been approved for participation in the Section 8 Rental Assistance program, and he/she has reported to us that because of the nature of his/her disability, he/she needs a Reasonable Accommodation for an extra bedroom which is required for their exclusive use. We ask that you review this patient's request and verify in your professional opinion, the existence of an impairment that substantiates the Reasonable Accommodation request. To help us make a determination, we would appreciate your evaluation based on your knowledge of the unique needs of your patient.

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.**

1. Does this patient have a disability as defined in Section 504 of the rehabilitation Act and Fair Housing Amendments?

☐ Yes ☐ No

2. Is it in your opinion that because of the nature of your patient's disability he/she requires a bedroom for their exclusive use?

☐ Yes ☐ No

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

   ☐ TEMPORARY (less than 12 months) If temporary, what is the approximate duration? _____

   ☐ PERMANENT (more than 12 months)

4. Please explain **how** this extra bedroom will accommodate your patient's disability.

   _____

   _____

   _____

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

   _____

   _____

   _____

6. If an extra bedroom is for medical equipment, please list approximate size and quantity of equipment needed.

   _____

   _____

   _____

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: _____