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 EXTRA BEDROOM

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, an extra bedroom is required for his/her exclusive use. To help us decide, 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 bedroom for his/her exclusive use?
   [ ] YES [ ] NO

2. If you answered "Yes" above, please give us an idea how long the need will last.
   [ ] Is expected to last less than 12 months. What is approximate duration? _____
   [ ] Is expected to last more than 12 months

3. Please explain <u>how</u> this extra bedroom will accommodate your patient's disability:
   _____
   _____

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

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

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 an extra bedroom. I further certify my professional opinion is in compliance with all applicable laws, regulations, standard industry practices and licensing guidelines. (Please <u>print</u> the information below.)

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

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

Professional's Signature: _____ Date: _____