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 A REASONABLE ACCOMMODATION FOR PATIENT TO RENT FROM A RELATIVE

Date: _____

Patient Name: _____ Patient's Age: _____

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 must rent from a relative. A relative is defined as a parent, child, grandparent, grandchild, brother, or sister. 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 needs to rent from a relative?
   [ ] YES [ ] NO

2. If you answered "Yes" above, please give us an idea how long the need will last.
   [ ] TEMPORARY (less than 12 months) [ ] PERMANENT (more than 12 months)

3. Please explain how renting from a relative will accommodate this person's disability:
   _____
   _____
   _____

Thank you for your cooperation on behalf of your patient.

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 the patient to rent from a relative. 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: _____ File Number/Name: _____