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 VOUCHER EXTENSION

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 requires an extension to the term of his/her Section 8 voucher, which is due to expire. 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 an extension to the term of his/her voucher?
   [ ] YES [ ] NO

2. Please explain the nexus between your patient's disability and the need for a voucher extension:

   _____

   _____

3. 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 voucher extension. 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: _____

Housing Specialist: **T: 858-694-** **F: 858-514-**