Safer Ground Hotel Voucher Program

Medical Verification

To Be Completed by A Licensed Health Care Professional

This form will verify that the applicant has a medical status that qualifies them for Safer Ground. Safer Ground and is a program designed to allow people who are experiencing homelessness and are highly vulnerable a safe space in a motel where they can take precautions to protect themselves from COVID-19.

This Verification Form is for:

Patient Name: _____

Patient Date of Birth: _____

Clinician Contact Information:

Organization Name (if applicable): _____

Address: _____

Phone #: _____ E-mail: _____

Contact Information for Coordinating Ongoing Medical Care (if different from Clinician Contact Information):

Organization Name: _____

Contact Person's Name and Title: _____

Address: _____

Phone #: _____ E-mail: _____

I am a credentialed and licensed health care professional trained to perform diagnostic and functional assessments of patients. Within my scope of practice, I have determined that the patient named above has the following diagnosable medical status. Check all that apply.

- ☐ Chronic heart disease, i.e., heart failure, coronary artery disease, congenital heart disease, cardiomyopathies, pulmonary hypertension
- ☐ Chronic obstructive pulmonary disease, emphysema, chronic bronchitis
- ☐ Type 2 diabetes mellitus
- ☐ Immunocompromised from a solid organ transplant, blood, or bone barrow transplant, immune deficiencies
- ☐ Sickle cell disease
- ☐ Obesity – Body Mass Index (BMI) >30
- ☐ Chronic kidney disease
- ☐ Poorly controlled HIV infection with a CD4 count <300 or not on HIV treatment
- ☐ Chronic steroid use or immune weakening medications
- ☐ Moderate to severe asthma
- ☐ Obstructive sleep apnea
- ☐ Active cancer diagnosis in treatment or not
- ☐ Chronic liver disease

My signature below indicates my verification that the above patient meets one or more of the medical statuses listed above.

Licensed Staff Name (printed): _____

Signature: _____ Date: _____

Professional License Type (MD, NP, or PA): _____ License #: _____

This form can be e-mailed to COVIDHOUSING@acgov.org.

Effective April 2020