Safer Ground Hotel Voucher Program
Individual High Risk Certification

This form is to be completed by the applicant and the service provider. This will **temporarily** serve as verification that the applicant has one of the medical conditions that qualifies them for Safer Ground. Safer Ground is a program designed to allow people who are experiencing homelessness and are highly vulnerable a safe space in a hotel where they can take precautions to protect themselves from COVID-19.

Verification from a medical professional must be submitted to COVIDHOUSING@acgov.org within 30 days.

This Verification Form is for:

Applicant Name: _____

Applicant's Date of Birth: _____

I, the applicant, certify that I have been diagnosed with one or more of the below medical statuses that puts me at higher risk of complications if exposed to COVID-19. 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 I am diagnosed with one or more of the conditions listed above. It also indicates my commitment to obtaining verification from a medical professional within 30 days.

Applicant's Signature: _____ Date: _____

To be completed by the Service Provider*:*

My signature below indicates that I will support the applicant to obtain verification of their qualifying medical status from a medical professional and submit that verification within 30 days to COVIDHOUSING@acgov.org.

Service Provider Name: _____

Service Provider Organization: _____

Service Provider Signature: _____ Date: _____

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

Effective April 2020