



Sample Physician's Verification of Need for Home Health Care Services Form

Note: A form such as this sample should be used to provide a format to a physician or other care provider in order to verify a tenant's need for home health care on an overnight basis or beyond normal visiting allowances. *All reasonable accommodation policies and forms should be reviewed by legal counsel prior to implementation.*

Physician's Name: _____

Address: _____

Date: _____

Re: Patient Name: _____

Property: _____

Address: _____

Dear Property Manager:

I have reviewed the medical condition of the above-listed patient. It is my professional opinion, hereby certified by my signature below, that the patient's medical condition requires and would substantially benefit from the attendance of a Home Health Care Provider. I believe that this type of support will continue to enable my patient to safely maintain an independent living situation.

Specifically, I believe that the patient requires and would benefit from the attendance of a Home Health Care Provider for the following number of nights per month: _____.

(Physician's Signature - Required)

(Physician's Phone Number - Required)

Note: This document is included within the *Housing Operations* section of CSH's *Toolkit for Developing and Operating Supportive Housing*, which is available at www.csh.org/toolkit2. This document has been adapted from CSH's *Supportive Housing Property Management Operations Manual*, which is available at www.csh.org/publications.