



MULTNOMAH COUNTY
LAND USE AND TRANSPORTATION PROGRAM
1600 SE 190TH Avenue Portland, OR 97233
PH: 503-988-3043 FAX: 503-988-3389
<http://www.multco.us/landuse>

HEALTH HARDSHIP MEDICAL VERIFICATION FORM

This form must be completed and signed by the physician and submitted with the application for a temporary health hardship dwelling.

I, _____ (print patient's name), in abrogation of my HIPAA* rights, authorize _____ (attending licensed physician) to disclose the information required for this form to help me obtain a Temporary Health Hardship Permit to allow the placement of a temporary dwelling on a property with an existing single-family residence for assistance in providing daily care needs to me. (MCC 33.0515, etc).

Patient Signature: _____ Date: _____

TO PHYSICIAN:

The above named person is applying to Multnomah County for approval to occupy a temporary health hardship dwelling, or is renewing a previously approved temporary health hardship dwelling. A temporary health hardship dwelling may be allowed when a patient has a demonstrated need for assistance with daily care as a result of age, physical impairment and/or poor health. **Daily care includes, but is not limited to, bathing, grooming, eating, medication management, walking and transportation. Daily care does not include financial management or the improvement or maintenance of property.**

In order to process this application, it is necessary that the patient's attending licensed physician certify that a need for daily care assistance exists, and that the impairment requires someone close by to assist them.

DOES THIS PATIENT REQUIRE ASSITANCE WITH DAILY CARE AS DESCRIBED ABOVE? YES _____ NO _____ IF YES, PLEASE FILL OUT THE BOX ON THE FOLLOWING PAGE THAT APPLIES TO THE SITUATION.

TURN PAGE OVER

INFORMATION CONTAINED WITHIN THIS APPLICATION IS PUBLIC INFORMATION

*HIPAA is the **Health Insurance Portability and Accountability Act**. Multnomah County is obligated to ask for this information in order to evaluate the approval criteria for a Temporary Health Hardship.

Does the owner of the property known as _____ (list property address) require assistance with daily care? YES _____ NO _____

If YES, _____ (Care Giver(s) name) will be moving onto the property if the Temporary Health Hardship is approved and will be providing assistance with the patients daily care needs.

List caregiver(s)' relation to the owner, current address(es) and phone number(s). (Use additional pages if necessary.)

If you answered "NO" above, the patient needing assistance with daily care will move into a temporary dwelling on property known as _____ (list property address).

Is there an individual(s) residing on the property listed above capable of providing the required daily care assistance? YES _____ NO _____

If YES, _____ (Care Giver(s) name), lives on the property that will provide assistance with daily care needs.

List Caregiver(s)' relation to the owner, address(es) and phone number(s). (Use additional pages if necessary.)

Print Doctor's Name: _____ Address: _____

Doctor's Signature: _____ City/State/Zip Code: _____

Medical License #: _____ Phone: _____

Date: _____

INFORMATION CONTAINED WITHIN THIS APPLICATION IS PUBLIC INFORMATION

*HIPAA is the **Health Insurance Portability and Accountability Act**. Multnomah County is obligated to ask for this information in order to evaluate the approval criteria for a Temporary Health Hardship.