Land Use Planning Division
1600 SE 190th Ave, Ste 116
Portland OR 97233
Ph: 503-988-3043 Fax: 503-988-3389
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 Dwelling for a 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 Dwelling for a 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 39.8700 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 ASSISTANCE WITH DAILY CARE AS DESCRIBED ABOVE?
YES _____ NO _____

IF YES, PLEASE FILL OUT THE INFORMATION 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 Dwelling for a Health Hardship.

Does the owner of the property, known as _____ (list property address), require assistance with daily care? Yes _____ No _____

If YES, _____ (Caregiver(s) name) will be moving onto the property if the Temporary Health Hardship is approved, and will be providing assistance with the patient's 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, _____ (Caregiver(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: _____

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