CODE COMPLIANCE

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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 or Wasco County ARA program qualification.

I,_____(printed patient's name), in abrogation of my HIPPA* rights, authorize_____(attending licensed physician) to disclose the information required for this form to help 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; or verification to meet minimum qualifications for the Wasco County Abatement and Recycling Assistance Program.

Patient Signature_____Date:_____

TO PHYSICIAN:

The above named person is applying to Wasco County for approval to occupy temporary health hardship dwelling, renewing a previously approved temporary health hardship dwelling, or trying to qualify for the Wasco County ARA program. A temporary health hardship dwelling may be allowed when a patient has 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.**

If qualifying for the Wasco County ARA Program and the above named person is the resident in charge of the property, qualifying criteria would include unable to maintain 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.

Information contained within this application is public information

*HIPPA is the Health Insurance Portability and Accountability Act. Wasco 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,_____(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.)

_____
_____
_____

Does the owner of the property, known as_____(list property address), require assistance with maintenance of their property? Yes___ No___

If yes, please list the activities that limit the property owner from maintaining their property.

_____
_____
_____
_____

Print Doctor's Name: _____
Address: _____
Doctor's Signature: _____
Medical License#: _____ Phone:_____
Date:_____

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