Health Care Utilization - 3rd Party Verification

Instructions: Please provide verification of frequent utilization of health care services (as defined below) using this form or by providing this content on agency letterhead.

This verification will help prioritize homeless and disabled individuals for permanent supportive housing opportunities in Alameda County.

This Verification of Health Care Utilization is for:

Patient Name: ____

Patient Date of Birth: ____

Health Care Provider Contact Information:

Organization Name (if applicable): ____

Address: ____

Phone #: ____

E-mail: ____

I am a health care provider who can attest to frequent contacts between health care service providers and the aforementioned patient. Frequent contacts are defined as one or more of the following in the past 12 months (check ALL that apply):

- ☐ 3 or more admissions to Cherry Hill Detox or Sobering Station
- ☐ 3 or more medical and/or psychiatric hospitalizations
- ☐ 5 or more Emergency Medical Services transports

My signature below indicates my verification of the above information for this patient.

Intern Name, if applicable (printed): ____

Signature: ______________________________ Date: ______________________

Licensed Staff Name (printed): ____

Signature: ______________________________ Date: ______________________

Professional License Type: ______________________ License #: ______________________