Health Care Diagnostic Verification

To Be Completed By A Licensed Health Care Professional

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

Patient Name: _____

Patient Date of Birth: _____

Clinician Contact Information:
Organization Name (if applicable): _____

Address: _____

Phone #: _____

E-mail: _____

I am a credentialed and licensed health care professional trained to perform diagnostic and functional assessments of patients. Within my scope of practice, I have determined that the patient named above has one or more of the following health condition(s) (check ALL that apply):

- ☐ 60 years of age or older AND one or more chronic health conditions: heart disease, emphysema/COPD, diabetes, asthma, cancer, or hepatitis C
- ☐ Kidney Disease/End Stage Renal Disease or Dialysis
- ☐ History of Frostbite, Hypothermia, or Immersion Foot
- ☐ End Stage Liver Disease or Cirrhosis
- ☐ HIV+/AIDS
- ☐ Arrhythmia
- ☐ Seizure Disorder
- ☐ Schizophrenia or Schizoaffective Disorder
- ☐ Tri-Morbidity
  - Mental health, learning, developmental, or other cognitive disability AND
  - Substance use disorder AND
  - Chronic health issue: heart disease, emphysema/COPD, diabetes, asthma, cancer, hepatitis C

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 #: _____

*Contact **HOME STRETCH***
fax: 1 (855) 658-5466, *email: HomeStretch@acgov.org, phone: (510) 891-8938*
mail: P.O. Box 29172, Oakland, CA 94612