Mashpee Housing Authority

Leila Botsford P.H.M.
Executive Director

DATE: _____

PHYSICIAN'S VERIFICATION OF SEVERE MEDICAL EMERGENCY

Applicant's Name: _____ **Control No.** _____

Applicant's Address: _____

I hereby authorize release of the requested information.

_____
Applicant's Signature

Dear doctor:

The above named applicant is seeking state-aided housing with this Authority and has indicated that he/she is being displaced or has been displaced from his/her current housing because of a severe medical emergency.

In order to determine whether to grant priority status for this applicant, we must secure verification of a qualifying severe medical emergency. Therefore, we would appreciate your completing the verification on the reverse and returning this form directly to the Housing Authority. A representative of the Authority may contact you at a later date to confirm the information.

Sincerely,

Leila Botsford

Leila Botsford, P.H.M.
Executive Director

PHYSICIAN'S VERIFICATION OF SEVERE MEDICAL EMERGENCY

Main Office
7 Job's Fishing Road, Mashpee, MA 02649
Tel: 508-477-6202 • Fax: 508-477-4231

Quashers Path Apartments
1 Carleton Drive, Mashpee, MA 02649
Tel: 508-539-7680 • Fax: 508-539-0003

E-mail: mashpeeha@capecod.net • Website: www.mashpeeha.org

PHYSICIAN'S VERIFICATION OF SEVERE MEDICAL EMERGENCY

1. Is the applicant or member of the applicant's household suffering from an illness or injury which poses a severe and medically documented threat to life or safety? (circle one)

YES NO NO OPINION

If YES, please explain:_____
_____
_____
_____

2. Is the applicant's current housing situation a cause of the illness or injury or is it a substantial impediment to treatment or recovery from this illness or injury? (circle one)

YES NO NO OPINION

If YES, please explain:_____
_____
_____
_____

3. How long has the applicant or household member been your patient? _____

4. For what are you currently treating the patient?_____

PHYSICIAN'S CERTIFICATION

I certify that the information provided above represents my professional judgment and is true and correct to the best of my knowledge and belief.

_____,MD
Signature

_____
Date

Name:_____

Address:_____

_____

Telephone: (____)_____

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YES NO NO OPINION

If YES, please explain:_____

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2. Is the applicant's current housing situation a cause of the illness or injury or is it a substantial impediment to treatment or recovery from this illness or injury? (circle one)

YES NO NO OPINION

If YES, please explain:_____

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3. How long has the applicant or household member been your patient? _____

4. For what are you currently treating the patient?_____

PHYSICIAN'S CERTIFICATION

I certify that the information provided above represents my professional judgment and is true and correct to the best of my knowledge and belief.

_____,MD _____

Signature Date

Name:_____

Address:_____

_____

Telephone: (____)_____