TRANSITIONAL FOOD & SHELTER

HOUSING * HELPING * HEALING

Medically Fragile Homeless

Verification of Medical Need - Physician's Referral

Date submitted: _____

PHYSICIAN: Please note that the MFH funds for housing the medically-fragile homeless of SLO County are very limited. These funds are for housing those who cannot be managed in congregate care and need 24/7 housing. Our program does not provide medical care but ensures access to meeting basic needs and transportation. Acceptance and placement in the individual studio apartments is determined by an oversight team who prioritizes based on need and availability after an in person initial assessment.

Patient's name (Print Clearly): _____

Age:_____ Gender _____ Homeless? Yes ☐ No ☐ City considered home? _____

Is person at medical risk if he/she is not sheltered 24/7 for one or more nights? Yes ☐ No ☐

Please state the medical condition which places this person at risk:

_____

_____

_____

Please state the reason why this person *cannot be* adequately sheltered at an overnight only and/or congregate care shelter in the county such as 40 Prado, ECHO, Warming Center or other). Please include why staying at the MFH housing during the day time hours is necessary for recovery:

_____

_____

_____

Date requested housing to begin?_____ Number of days requested?_____

(Please state the minimum number of days that you judge the person would have to remain to ensure recovery)

Will the person need on-site care while in the MFH housing? Yes_____No____

If so, who will provide this care? _____

Your Printed Name_____Date: _____

Your Signature:_____Phone: _____

FAX completed form to 805.462.8901

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