



# COVID-19 HOTEL PROGRAM APPLICATION

KatherineB@ODVN.org

## Reimbursement Request

## Direct Pay Request

### Program Information

**Program Name:**

**Advocate Name:**

**Advocate Phone Number and Email:**

### Client Information

**Client Name:**

**Client Phone Number:**

**Number of children with client:**

### Hotel Information

**Hotel Name:**

**Rate:**

### For direct pay requests (not needed if requesting reimbursement)

**Hotel contact information:**

**How many beds are needed?**

**Does the client have any pets? Yes      No**

If yes, please describe:

**Does the client have any ADA needs? Yes      No**

If yes, please specify:

**Does your program offer 24-hour advocacy? Yes      No**

If no, please name a partner organization that does provide 24-hour advocacy:

Please send this form to Katherine Brandt at [KatherineB@odvn.org](mailto:KatherineB@odvn.org).

Revised November 2020



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### For reimbursement requests (not needed if requesting direct pay)

**NOTE: ODVN must receive appropriate documentation (a hotel invoice) before a check can be issued.**

**Make check payable to:**

**Mail check to:**

### Explanation of need

**Dates of stay:**

**Please check one and describe below if necessary:**

- Client has been diagnosed with COVID-19 or is symptomatic
- Client has been exposed to COVID-19 and needs to quarantine
- Client is being moved from a shelter to de-congregate
- Cannot find a shelter able to house client
- Client/client's family would be at a high COVID-19 risk in a shelter
- A shelter setting would not be appropriate for this client for another reason (please describe below)
- Other (please describe below)

**Please describe any other reasons why a temporary hotel stay is the best plan for this survivor at this time:**

**Hotel stays are ideally 14 nights. What is the housing plan for this survivor after a two week stay?**

**Has your client exhausted all other resources for assistance? Yes      No**

**Is this a request that would not qualify for general Relocation & Safety Assistance funding or reimbursement? Yes      No**

**Advocate Signature and Date:**

**Please send this form to Katherine Brandt at [KatherineB@odvn.org](mailto:KatherineB@odvn.org).**

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