COVID-19 HOTEL PROGRAM APPLICATION

HotelProgram@ODVN.org

Reimbursement Request   Direct Pay Request

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

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 (either nightly or for entire stay):

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 HotelProgram@odvn.org.

Revised March 2021

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Explanation of need

Dates of stay (please be specific):

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:

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