CITY OF LAREDO
COMMUNITY DEVELOPMENT DEPARTMENT

Community Development Block Grant
COVID-19 Quarantine Motel Voucher Program

EQUAL HOUSING OPPORTUNITY

ISOLATION REFERRAL FORM

Date of Referral: _____

HEALTH PROVIDER INFORMATION:

Referring Health Provider Name: _____

Contact Name: _____ Title: _____

Phone Number: _____ e-mail: _____

APPLICANT INFORMATION:

Name: _____ Social Security Number: _____

DOB (MM/DD/YYYY): _____ e-mail: _____

Home Address: _____ Phone Number: _____

REASON TO QUARANTINE:

☐ Positive Case

☐ Waiting for Results

☐ Other, please explain

_____

_____

INFORMATION FOR QUARANTINE PERIOD PURPOSES:

Symptomatic Cases Symptom Onset Date: _____

Asymptomatic Cases Positive Test Date: _____

NOTES:

_____

_____

Health Care Provider's Staff Signature: _____ Date: _____

PLEASE RETURN THE COMPLETED AND SIGNED FORM TO CDADMIN@CI.LAREDO.TX.US

Please contact the City of Laredo Community Development Department at (956)795-2675 if you have any questions or need additional information. In order to avoid illegal duplication of this form, staff will contact the health provider to confirm that the individual was referred to our program, prior to approving the assistance.