AUTHORIZATION TO RELEASE INFORMATION
REGARDING REQUIREMENT OF A LIVE-IN AIDE

The individual named below is an applicant/tenant of housing which is subsidized through the Department of Housing and Urban Development. This individual has authorized by signature below your release of the requested information. The information you provide will be used only for the purpose of determining this family's need for a live-in aide and for approval of the live-in aide selected by the family. We are required to complete our verification process in a short time period and would appreciate your prompt response. A self-addressed envelope has been included for your convenience or you may fax the completed form to me at the number below. If you have any questions, please feel free to contact our office. Thank You for your cooperation.

PHA Representative's Signature _____ Telephone Number _____ Fax Number _____

I,_____hereby authorize_____to provide the PHA with information requested to verify my need for a live-in aide or in-home caregiver.

Signature:_____Social Security Number_____Date:_____

Box below to be completed by doctor, psychiatrist, licensed physical therapist, state certified professional, or reliable 3rd party who is in a position to be familiar with client's medical condition, disability or handicap.

Does the above person require a live-in aide?_____yes_____no *If yes, please complete the following:*

During what hours are the services of a live-in aide required? ____nighttime/sleeping hours only

____daytime hours ____24 hours a day ____other *(specify)* _____

How many days per week are the services of a live-in aide required? ____7 days per week

____weekdays only ____weekends only ____other *(specify)* _____

How long will a live-in aide be required?_____indefinitely ____1 month or less ____1 – 3 months

Special qualifications required of live-in aide to meet patient's needs (*check all that apply*)

____LVN ____RN ____Physical Therapist ____ability to lift/carry more than 50 lbs

____ability to lift/carry over 100 lbs ____ read/speak Spanish ____read/speak English

____other *(please specify)*_____

____no special qualifications are required

*Signature of Medical Professional*_____ *Date*_____

*Address*_____ *Telephone #*_____

WARNING: Section 1001 of Title I8 of the U.S. Code makes it a criminal offense to make willful false statements or misrepresentation to any Department or Agency of the United States as to any matter within its jurisdiction.

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REQUEST FOR APPROVAL OF LIVE-IN AIDE

Name of family member requiring a live-in aide:_____

Head of Household:_____Social Security # _____

The PHA may approve a request for a live-in aide as a reasonable accommodation for an elderly person, a near elderly person or a person with disabilities, subject to all of the following conditions being met:

1. The need for a live-in aide is verified by the family member's medical doctor, psychiatrist, licensed physical therapist, state certified professional, or reliable 3rd party who is in a position to be familiar with individual's medical condition, disability or handicap. *(Family must sign a release form allowing the PHA to verify information.*);
2. The family selects a live-in aide qualified to provide the services stipulated on the live-in aide verification form and provides the PHA with the name and screening information for the proposed live-in aide;
3. The live-in aide agrees that he/she has no right to remain in the unit once his/her services are no longer required;
4. The family assumes all liability and responsibility for the actions of the live-in aide and accompanying family members, if applicable; and
5. The live-in aide selected by the family (and all family members accompanying the live-in aide, if applicable) meet all the following PHA screening requirements:
    a. Executes release forms for verifications of all screening criteria;
    b. Is not now and has not for at least 1 year been a member of the family's household or listed on a lease of the family requesting approval of the live-in aide;
    c. Has never been a member of a household that was evicted from public housing or had other housing assistance terminated by this or any other PHA;
    d. Does not owe this PHA or any other PHA money;
    e. Is a U.S. citizen or has eligible immigration status;
    f. Has not been banned from PHA property currently or historically;
    g. Is not a registered sex-offender;
    h. Has no drug related or violent criminal history;
    i. Has no history of destruction of property or disturbance to neighbors;
    j. Is not responsible for support of the person for whom they will be providing services; and
    k. Would not be living in the unit if not there to provide live-in aide services.

Full name of proposed live-in aide: _____

Social Security #_____Date of Birth:_____ Phone # _____

Current Address _____

Is the live-in aide related to any family member?_____If yes, describe relationship: _____

Live-in aide's family members, if any, who will also be living in the unit with the live-in aide:

Name	Relationship	Date of Birth	Sex	Social Security #

_____ _____
Applicant/Resident/Program Participant Signature Date

_____ _____
Signature of Proposed Live-in-Aide Date

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