VERIFICATION OF NEED FOR CAREGIVER OR LIVE-IN-AIDE

DATE OF 1st REQUEST: ____________
DATE OF 2nd REQUEST: ____________

TO: ____________________________________
Name

____ ____________________ __________________
Address City, State Zip Code Telephone Number Fax Number

RE: ____________________________________ SSN: ____________________________________
Applicant/Client Name

____
Applicant/Client Address City, State Zip Code

Dear Sir/Madam;

We are required to verify the incomes, expenses and other information of applicants/participants for eligibility and continued occupancy in the Housing Choice Voucher and Public Housing Programs. We ask your cooperation by supplying the information requested below about the referenced person. We will use any information you provide only to determine the family's eligibility for an accommodation under Section 504 of the National Rehabilitation Act and pledge to keep the data in strict confidence.

We would greatly appreciate your prompt return of this letter. A self-addressed return envelope is enclosed. Note that the person referenced has authorized your release of the information. If you have any questions, please feel free to contact our office. Thank you for your cooperation.

____ ____
PHA Representative Name Telephone Number

APPLICANT/PARTICIPANT RELEASE OF INFORMATION

I hereby authorize the above captioned verifier to release the information requested below.

Name: ______________________________ Signature: ______________________________ Date: ____________________

TO BE COMPLETED BY A QUALIFIED EVALUATOR OR MEDICAL PROVIDER

1. Is the applicant disabled? ☐ Yes ☐ No
2. Is the disability expected to be of long-continued or of indefinite duration? ☐ Yes ☐ No
3. Is the applicant in need of the assistance of a Caregiver or Live-In-Aide to assist with Activities of Daily Living?
   ☐ Yes ☐ No
   If yes, please describe the degree of assistance needed on the next page.

4. Please place ranking number in the box adjacent to the following Activities of Daily Living (ADL):

Activities of Daily Living

- ☐ Getting in/out of bed
- ☐ Getting in/out of a chair
- ☐ Moving throughout the home
- ☐ Toileting
- ☐ Bathing
- ☐ Dressing/undressing
- ☐ Taking medication
- ☐ Preparing meals/washing dishes
- ☐ Doing laundry/cleaning house
- ☐ Shopping
- ☐ Admitting visitors
- ☐ Paying bills, managing financial affairs

Ranking Key

1. Can perform independently (without assistance)
2. Can perform independently (with mechanical assistance)
3. Requires minimal assistance
4. Requires moderate assistance
5. Requires total assistance

5. Please provide a general description of the type of assistance, time of day and duration of assistance: __________

____

6. Describe any assistive devices or special equipment used (wheelchair, walker, oxygen, etc.): __________________

____

7. Is the Caregiver a parent, guardian or child who already lives with the disabled person? ☐ Yes ☐ No

OR

8. Is this a new Caregiver or Live-In-Aide who will move in to give full time care? ☐ Yes ☐ No

OR

9. Is the need for the Live-In-Aide only on an occasional basis, due to illness? ☐ Yes ☐ No

I certify that the above information is true and correct.

Name of Person Completing Form ______________________ Title ______________________

Signature ______________________ Date ______________________

Name of Organization ______________________ Telephone Number __________ Fax Number __________

Address ______________________ City, State ______________________ Zip Code __________