PUBLIC HOUSING and COMMUNITY DEVELOPMENT

LIVE-IN AIDE VERIFICATION

NAME: _____ CLIENT #: _____
*(**Head of household (HOH)**)*

Adress:_____

Name: _____
(Print name of household member for whom the Live-in Aide is requested)

REQUESTED LIVE-IN AIDE INFORMATION:

Name: _____ Phone number: _____

Address: _____

Please return to: _____
(Name of PHCD Employee)

_____ _____
(Address of PHCD Employee) (Phone/Fax of Employee)

DEFINITION OF PERSON WITH DISABILITIES

Under federal law, an individual is disabled if he/she has a physical or mental impairment that substantially limits one or more major life activities; has a record of such impairment; or is regarded as having such impairment.

The HOH named above has applied for, or is a participant in, a housing program provided by Public Housing and Community Development (PHCD). The HOH has requested a Live-in Aide and must obtain verification that the Live-in Aide is needed. Please answer the questions below and return the form to the PHCD employee listed above.

INFORMATION REQUESTED

1. Is the Household Member disabled as defined above? ☐ YES ☐ NO

2. Is a live-in aide essential to the care and well-being of the Household Member?
☐ YES ☐ NO If yes, for how long? _____

3. If the response to question # 2 is "Yes", then please explain what the live-in aide would do that is essential to the Household Member's care and well-being.

_____

_____

4. Does the Household Member require a live-in aide on a temporary basis?
☐ YES ☐ NO

5. If the response to question # 4 is "Yes", please provide an estimate of the duration of time (in months and/or years) during which the live-in aide must provide services that are essential to the care and well-being of the Household Member.

_____

6. **Using the checklist below, indicate the activities of daily living (ADLs) with which the person requesting a live-in aide requires assistance and with which the live-in aide would provide assistance.**

CHECKLIST: ACTIVITIES OF DAILY LIVING WITH WHICH CLIENT REQUIRES ASSISTANCE	
ACTIVITIES OF DAILY LIVING (ADL) *(Check applicable)*	**CLIENT REQUIRES ASSISTANCE WITH THESE ADLs** **Y**= Yes (or) **N**= No *(Enter Y or N as applicable)*
☐ Walking	
☐ Standing	
☐ Sitting	
☐ Transfer to/from bed, chair/couch, bathtub and/or shower	
☐ Cooking/food preparation	
☐ Feeding him or herself	
☐ Drinking	
☐ Shopping	
☐ Housecleaning	
☐ Laundry	
☐ Bathing	
☐ Grooming	
☐ Dressing (clothes)	
☐ Taking medication	
☐ Application of wound dressings (changing/applying cloth or adhesive bandages, antiseptics, etc.)	
☐ Handling financial matters	
☐ Decision-making	
☐ Memory	
☐ Lifting	
☐ Reaching	
☐ Other (Please Specify in non-technical terms that simply describe the ADLs with which the client needs assistance)	

STATEMENT OF VERIFICATION SOURCE

I, _____ do hereby certify that the information provided above is correct and accurate to the best of my professional knowledge.
(Print Name)

_____ Date _____
(Signature)

Name of Organization/Company _____ ***Title of Verification Source:*** _____

License Practice #: _____ ***Address:*** _____

Telephone: _____ ***Fax:*** _____

Warning: Title 18, US Code Section 1001, states that a person who knowingly and willingly makes false or fraudulent statements to any Department or Agency of the United States is guilty of a felony. State law may also provide penalties for false or fraudulent statements.