LIVE-IN AIDE CERTIFICATION

____

(Head of Household Name)

I, ______________________________, do hereby certify that the following statements are true and correct.

1. I will reside in the above named resident's unit while performing the duties of live-in aide.
2. I am not obligated for the support of the elderly, handicapped or disabled family member named above.
3. I would not be living in the above named resident's unit except to provide care of the elderly, handicapped, or disabled family member.
4. I understand that my income will not be counted for the purpose of determining eligibility or rent.
5. I understand that I cannot be considered the remaining member of the tenant family in the event that the elderly, handicapped or disable family member is no longer a member of the family composition.

______________________________ ______________

Signature of Live-In Aide Date

____

Printed Name of Live-In Aide

______________________________ ______________

Witness Date

"We do business in accordance with the Fair Housing Act"

Request for Live-In Aide

Request made by:

Name ______________________________ Phone# ______________________

Address ____

Please answer **the following** questions:

1. Which family member requires a live-in aide? ______________________________
2. Explain how a live-in aide is essential to the care and well-being of this family member: ________
   ____
3. Is the live-in aide needed: ( ) Full-time ( ) Part-time
4. List any qualified health professionals who can verify the need for a live-in aide.

   Name/Title______________________________ Phone #______________________

   Name/Title______________________________ Phone # ______________________
5. What is the current address of the proposed live-in aide?

   ____
   Street City/State Zip Code
6. What is the previous address of the proposed live-in aide?

   ____
   Street City/State Zip Code
7. How much will the live-in aide be paid? $ ____________________Per______________
8. Is the proposed live-in aide a relative? ( ) Yes ( ) No

I certify that the information contained is true and correct.

Signature: ______________________________________ Date: ____________________

WARNING! Title 18 Section 1001 of the United States Code, states that a person who knowingly and willingly makes a false or fraudulent statements to any department or agency of the United States is guilty of a felony.

"We do business in accordance with the Fair Housing Act"

MEDICAL CERTIFICATION FOR LIVE-IN AIDE

Name ____

Address ____

The services to be performed by the live-in aide are:

____

____

____

____

____

____

List special skills needed by the live-in aide:

____

____

____

I, ____, hereby certify that the services
(Name of Medical Source)
of a live-in aide are essential to the well-being of the person listed above.

____
Signature of Medical Source Date

PLEASE ATTACH YOUR BUSINESS CARD OR STAMP YOUR NAME AND BUSINESS ADDRESS IN THE SPACE BELOW.