# LIVE IN AIDE VERIFICATION

**(The use of white out, black out, or alteration of original information will void this document)**

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|---|---|---|---|---|---|
| Project Name: | | Unit ID: | | Date: | |
| Applicant/Tenant: | | SSN: | | | |

**Physician Contact:**

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|---|---|---|---|---|---|---|---|
| **Office Name:** | | | **Contact Person:** | | | | |
| **Address:** | | | **Phone:** | | | **Fax:** | |
| **City:** | | **State:** | | **Zip:** | | **Email:** | |

**My Signature Authorizes the Release of this Information:**

**Applicant/Tenant Signature** **Date**

The individual named directly above is an applicant/tenant of the IRC § 42 **Low Income Housing Tax Credit Program**. The information provided will be used to determine eligibility for the program and remains confidential to the satisfaction of that stated purpose only. Your prompt response is crucial and would be greatly appreciated.

Sincerely,

RETURN THIS FORM TO:

Project Owner/Management Agent

**THIS SECTION TO BE COMPLETED BY PHYSICIAN**

The applicant/tenant listed above has indicated that he/she is disabled and requires a live in aide in order to have equal access to housing the same as if he or she was not disabled. The LIHTC program has specific verification requirements for all households indicating the need for a live in aide. These requirements include (but are not limited to): (1) the aide is determined to be essential to the care and well being of the applicant/tenant; (2) the aide is not obligated for the financial support of the applicant/tenant; (3) the aide would not be living in the apartment for any reason except to provide the necessary supportive services.

The applicant/tenant has indicated that you are a third party professional competent to verify the need for the requested accommodation of a live in aide. We ask that you provide the following general information to determine if a live in aide is required. Please note that the information provided should respond to the general questions and not disclose any confidential information regarding the nature of the disability of the applicant/tenant.

**Information Requested:**

Is the applicant/tenant disabled as defined below? **[ ] YES** **[ ] NO**

In your professional opinion, and with knowledge of the applicant/tenant's disability, does the applicant/tenant require the services of a live in aide in order to enjoy the use of the dwelling? **[ ] YES** **[ ] NO**

How many hours of care or assistance are needed by the applicant/tenant each day? _____

Is more than one aide to occupy the unit? **[ ] YES** **[ ] NO** Number of aides needed: _____

Under applicable law, an individual is disabled is he/she has, is regarded as having or perceived as having a physical or mental impairment that limits a major life activity such as caring for one's self, performing manual tasks, participating in social activities, walking, seeing, hearing, speaking, breathing, learning and working, and includes but is not limited to conditions such as cerebral palsy, autism, epilepsy, muscular dystrophy, multiple sclerosis, cancer, heart disease, Human Immunodeficiency Virus Infection, mental retardation, and emotional illness. This definition does not include sexual behavior disorders, compulsive gambling, kleptomania, pyromania, or psychoactive substance use disorders resulting from current unlawful use of controlled substances or other drugs.

Signature Date

Name and Title of Person Supplying the Information

**NOTE:** Section 1001 of Title 18 of the U.S. Code makes it a criminal offense to make willful false statements or misrepresentations to any Department or Agency of the United States as to any matter within its jurisdiction