LIVE-IN AIDE VERIFICATION

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

THIS SECTION TO BE COMPLETED BY PHYSICIAN

The applicant/tenant listed below has indicated that he/she requires a live-in aide in order to have equal access to housing. The applicant/tenant has indicated that you are qualified to verify the need for the requested accommodation of a live-in aide. The LIHTC program has specific verification requirements for all households indicating a need for a live-in aide, including, but not limited to: (1) the aide is there for the sole purpose of providing supportive services essential to the member's care and well-being; and (2) the aide would not otherwise be occupying the unit except to provide the necessary supportive services. The information provided should respond to the general questions and not disclose any confidential information regarding the nature of the disability of the household member.

Under applicable law, an individual is disabled if 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.

Information Requested:

1. Is the household member disabled as defined above? **[ ] YES [ ] NO**
2. In your professional opinion, and with knowledge of the applicant/tenant's condition, does the applicant/tenant require the services of a live-in aide in order to enjoy the use of the dwelling? **[ ] YES [ ] NO**

Signature _____ Date _____

Name and Title of Person Supplying the Information _____

By singing above, I certify, under penalty of perjury, that the information presented in this Verification is true and accurate to the best of my knowledge and belief. I further understand that providing false representations herein constitutes an act of fraud.

THIS SECTION TO BE COMPLETED BY MANAGEMENT

Project Name:		**Unit ID:**	
Applicant/Tenant:		**Date:**	

Physician Contact:

Office Name:			**Contact Person:**				
Address:			**Phone:**				
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,

Project Owner/Management Agent

RETURN THIS FORM TO: