OHIO **HOUSING** FINANCE AGENCY

Live-In Caregiver
Verification of Need

To: Name _____
Address _____
_____
Email _____
Phone _____
Fax _____

From: Name _____
Address _____
_____
Email _____
Phone _____
Fax _____

Re: Name _____ Address _____
Last 4 Digits of SS # _____ _____

Release: I hereby authorize the release of the requested information. Information obtained under this consent is limited to information that is no older than 12 months. There are circumstances that would require the owner to verify information that is up to 5 years old, which would be authorized by me on a separate consent attached to a copy of this consent.

_____ _____
Applicant/Tenant Date

You do not have to sign this form if either the requesting organization or the organization supplying the information is left blank.

The individual named above has applied for tenancy or is currently residing in a community that was developed under the U.S. Department of Housing and Urban Development, U.S. Department of Agriculture (Rural Housing) or Section 42 of the IRS code which is administered by the State. Federal regulations require the housing owner to annually verify the household's income and other information related to eligibility. The information you provide will be used only for the purpose of determining the household's eligibility for the program and will be kept in strict confidence. We are required to complete our verification process in a short time period and would appreciate your prompt response. Return this form via email or fax number as it appears above. If you have any questions, please feel free to contact our office. Thank you for your cooperation.

Information Being Requested:

The individual named above and whose signature permits the release of this information to the sender of this request has indicated that he/she requires a live-in caregiver during the next year. As the owner's agent, we are required to obtain a third party verification of this information. The individual has given you as the attending physician with knowledge of conditions requiring the need for a live-in caregiver. Please complete and sign the statement below.

As the attending physician of _____ and with knowledge of this individual's physical and mental health history, I certify that his/her quality of life would be greatly improved with a live-in caregiver. It is not unreasonable that he/she requires the need of a live-in caregiver to maintain independence in the community.

_____ _____
Signature Date

_____ _____
Name/Title of Person Supplying Information Organization

_____ _____ _____
Phone # Fax # Email Address

Under penalties of perjury, I certify that the information provided herein is true and accurate to the best of my knowledge. The undersigned further understands that providing false representation herein constitutes fraud.