Live-In Care/Aide Verification of Need

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

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

RE:
Name: _____ Address: _____
SSN: _____
_____
_____

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 / Resident 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 residency 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 family's income and other information related to eligibility. The information you provide will be used only for the purpose of determining the family'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. If this correspondence is being conducted via fax, please return this form to our 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 and will have a live-in caregiver residing with him/her 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 care attendant. 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.

Certification: I attest, under penalty of perjury, that the above information is true and accurate to the best of my knowledge.

_____ _____
Name / Title of Person Supplying Information Firm / Organization

_____ _____
Signature Date

_____ _____ _____
Phone # Fax # E-mail

Penalties for misusing this content: Title 18, Section 1001 of the U.S. Code states that a person is guilty of a felony for knowingly and willingly making false or fraudulent statements to any department of the United States Government. HUD and any owner (or any employee of HUD or the owner) may be subject to penalties for unauthorized disclosures or improper use of information collected based on the consent form. Use of the information collected based on this verification form is restricted to the purposes cited above. Any person, who knowingly or willingly requests, obtains or discloses any information under false pretenses concerning an applicant or participant may be subject to a misdemeanor and fined not more than $5,000. Any applicant or participant affected by negligent disclosure of information may bring civil action for damages, and seek other relief, as may be appropriate, against the officer or employee of HUD or the owner responsible for the unauthorized disclosure or improper use. Penalty provisions for misusing the social security number are contained in the Social Security Act at 208(a), (6),(7) and (8). Violation of these provisions are cited as violations of 42 U.S.C.408 (a), (6), (7) and (8).