Live-In Aide Request for Verification

(California Tax Credit Properties)

Date: _____________

Household Member's Name: _______________________________________

To: ____________________________________ From: ___________________________________

____________________________________ ___________________________________

____________________________________ ___________________________________

The household member named above has applied for or is currently residing in a unit that is part of the Low Income Housing Tax Credit program under IRS Section 42. The household member 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 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 household member named above has indicated that you are a third-party professional competent to verify the disability and the need for the requested accommodation. We ask that you provide the following general information to determine if a live-in care attendant is required to provide necessary supportive services in order for the member to use and enjoy the dwelling.

Please Note: 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.

I hereby authorize the release of the information on this verification form:

____ ________________________________

Household Member's Signature Date

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Information Requested:

1. Is the household member disabled as defined below? ☐ Yes ☐ No
2. In your professional opinion, and with knowledge of the member's disability, does the member require the services of a live-in care attendant in order to use and enjoy the dwelling? ☐ Yes ☐ No
3. Is the household member's disability permanent and/or without the potential for improvement such that the household member would continue to need the services of a live-in care attendant? ☐ Yes ☐ No
   (CTCAC will require that any "No" response be verified annually)
4. Does the member require more than one aide to occupy the unit? ☐ Yes ☐ No
   Number of Aides needed: _________

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 the current unlawful use of controlled substances or other drugs.

Printed name of Person supplying information: ____

Title of Person supplying information: ____

Firm/Organization: ____

Phone Number: ______________________________________ **Fax:** __________________________________

Signature of Person supplying information: ____ **Date:** ___________

By signing 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.

Please attach a business card or stamp here:

www.onlainuisa.com