Pinellas County Housing Authority
11479 Ulmerton Road, Largo, FL 33778
Phone: 727.443.7684 • TDD: 800.955.8770
Fax: 727.489.0773 • TTY: 800.955.8771
EMAIL: aclute@pinellashousing.com
www.PinellasHousing.com

LIVE-IN AIDE VERIFICATION FORM

Please complete the form below. If you submit this form with missing or incorrect information, this form will be returned to you to complete, which will delay the processing of your request. Requests will be reviewed and responded to based on date/order received and my take up to 30 days for a determination. Reasonable accommodation determinations may be reevaluated annually at PCHA's discretion.

Case Manager/Property Manager Name: _____ Date: _____

Health Care provider or other Verification Source (Please Print Legibly)

Name: _____ Phone: _____

Address: _____Fax:_____

VERIFICATION INSTRUCTIONS: The person named below has applied for or is receiving federal assistance through one of our programs. This person has requested a Live-In-Aide and must obtain verification that the Live-In Aide is needed. We are required to verify that the household member qualifies as "disabled" under federal law, and to determine the disability related need and/or nexus between the Live-In Aide and individual disability. I understand that oral verification from health care provider may be required.

HOUSEHOLD MEMBER

Name: _____ Date of Birth: _____

Address: _____

Phone: _____ Email: _____

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

SIGNATURE: _____ DATE: _____

REQUESTED LIVE-IN AIDE INFORMATION

Name of Prospective Live-in Aide: _____ Phone Number: _____

Address: _____

Relationship to household member: _____

Does Live In Aide intend to add children, spouse, or another person to household? _____

What types of activities does the Live in Aide do outside of the home? _____

How does the Live In Aide support oneself? _____

Does the Live In Aide work, go to school, or care for any one else? _____

Live in Aide Certification: I swear and attest that I am not currently or planning to work, go to school, or have any other obligations outside of the home while I am living in the household as a Live In Aide.

_____ _____
Live In Aide Signature Date

Provide documentation below for each prospective member of the household and Live in Aide.
The following information must be provided to Housing Advisor or Property Manager:

- 1) Social Security Card; 2) State Issued Photo ID; 3)Birth Certificate or Voter's ID; 4) State Issued Photo ID; 5) Local Background Check/Police Report.

INFORMATION REQUESTED (Information below to be filled out by health care provider)

1. Is the household member disabled as defined below? ☐ Yes ☐ No

2. Is the Live-In Aide essential to the care (medical necessity) to this household member? ☐ Yes ☐ No

3. Is the household member's disability permanent and without the potential for improvement?
☐ Yes ☐ No

3. If Live-In Aide is required on temporary basis, please provide an estimate time of duration. _____

4. How many hours of assistance by Live-in Aide are needed each day? _____

5. Is the Live-In-Aide requesting a spouse, child, or immediate family member to accompany them?
☐ Yes ☐ No If Yes, please include name, age, and relationship.

_____

_____

6. Please indicate the activities of daily living (ADLs) with which the person requesting a Live-In Aide requires assistance and with which the Live-In Aide would provide**. Please fill out the 24 Hour Day calendar for ADLs**

_____

_____

DEFINITION OF DISABILITY

Under Federal Law, an individual is disabled if he or she has a physical or mental impairment that substantially limits one or more major life activity, has a record of said impairment or is regarded as having said impairment.

The term physical or mental impairment includes but is not limited to such diseases and conditions as orthopedic visual, speech and hearing impairment, cerebral palsy, autism, epilepsy, muscular dystrophy, multiple sclerosis, cancer, heart disease, diabetes, human immunodeficiency, virus infection, mental retardation, emotional illness, drug addiction and alcoholism. The definition does not include any individual who is a drug addict and who is currently using illegal drugs or an alcoholic who poses a direct threat to property or safety because of alcohol use [24 CFR Part 8.3 and HUD Handbook 4350.3 (Exhibit 2-2)].

Medical Professional Supplying Information:

Name: _____ Title: _____

License Number: _____ Business/Professional Organization: _____

_____ _____

Signature Date

"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.

Twenty -Four (24) Hour Day Calendar
Live In Aide (ADLs) Care Schedule

Please state the essential care required for this household member.

Time	Care Required	Time	Care Required
5:00 AM		**6:00 PM**	
6:00 AM		**7:00 PM**	
7:00 AM		**8:00 PM**	
8:00 AM		**9:00 PM**	
9:00 AM		**10:00 PM**	
10:00 AM		**11:00 PM**	
11:00 AM		**12:00 AM**	
12:00 PM		**1:00 AM**	
1:00 PM		**2:00 AM**	
2:00 PM		**3:00 AM**	
3:00 PM		**4:00 AM**	

4:00 PM			
5:00 PM			

Comments: _____

Health Care Provider Signature _____