

### Verification of Need for Live-In Aide

Physician: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

Fax #: \_\_\_\_\_

RE: \_\_\_\_\_  
Applicant/Resident Name

The above Applicant/Resident is applying to/participating in a housing program that requires verification of the need for a live-in aide. The individual has signed a release below giving you permission to supply us with information. The information provided will remain confidential. Please return the completed form to the address/fax below.

*I certify that this verification has been sent directly to the physician and was not hand-carried by the applicant/tenant or any other interested party.*

\_\_\_\_\_  
Signature of Owner/Agent Title Date

\_\_\_\_\_  
Owner/Agent's Address Owner/Agent's Fax Number

**Consent to Release Information:** My signature below authorizes verification of my employment information.

\_\_\_\_\_  
Applicant/Resident Signature

\_\_\_\_\_  
Date

**Physician: Please select an answer to the below question.**

The above listed applicant:  DOES  Does NOT require the services of a live-in aide.

Physician Comments: \_\_\_\_\_

**WARNING: Section 1001 of Title 18 of the U.S. Code makes it a criminal offense to make willful, false statements of misrepresentation to any Department or Agency of the U.S. as to any matter within its jurisdiction.**

\_\_\_\_\_  
Signature of Physician Title Date

Telephone #: \_\_\_\_\_