

## LIVE-IN CARE ATTENDANT VERIFICATION

Name of Applicant/Tenant \_\_\_\_\_

Date \_\_\_\_\_

**The individual named directly above is an applicant/tenant of a housing program and has requested a live-in care attendant. The information provided will remain confidential for satisfaction of the stated purpose only. Your prompt response is crucial and greatly appreciated.**

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### TO BE COMPLETED BY MEDICAL PROVIDER OR CASE MANAGER:

Is a live-in care attendant required for the care and well-being of the above named individual? **Note: we are not requesting details of the medical history or disability of the applicant/tenant.**

Please check one:    YES       NO

Additional comments: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
Name of Person Verifying Information

\_\_\_\_\_  
Title of Person Verifying Information

\_\_\_\_\_  
Signature of Person Verifying Information

\_\_\_\_\_  
Date

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

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



We encourage and support the nation's affirmative housing program in which there are no barriers to obtaining housing because of race, color, religion, sex, national origin, handicap or familial status.

