HARRISONBURG
REDEVELOPMENT AND
HOUSING AUTHORITY
P.O. BOX 1071 ✦ HARRISONBURG, VA 22803
Phone/VTDD 540-434-7386 ✦ Fax 540-432-1113

LIVE-IN AIDE REQUEST
COMPLETED BY CLIENT

Person Needing Accommodation		Head of Household (if different)
Unit & Street Address	City, State, Zip	Phone

1. I am elderly, near elderly, and/or disabled: ☐yes ☐no
2. Due to my condition, a live-in aide is necessary to afford me equal use & enjoyment of my housing: ☐yes ☐no
3. How will a live-in aide will help you use and enjoy housing (*you do not have to disclose the disability*), and why is a daily in-home worker is not equally effective as a reasonable accommodation?

4. The person I have selected as my live in aide is: (*check here if you have not yet selected an aide* ☐)

Name	Relationship	Sex	SSN	Birth Date
Current Address			Phone	
☐Own ☐Rent (IF rent, provide landlord name & phone #)				

5. This person is related to me: ☐ yes ☐ no (if yes, explain relationship)

6. I certify that the person I have selected to be my live-in aide (*initial all*):
   - ____ is capable and qualified to provide the care I require
   - ____ will reside in the unit with me
   - ____ was not previously a member of my household
   - ____ is not obligated for my support
   - ____ will not contribute to the cost of rent or utilities
   - ____ will maintain separate finances from me
   - ____ will not share any bills or expenses with me
   - ____ has no other reason to live in the unit except to provide necessary supportive services and care to me
   - ____ is not providing me any financial compensation for being allowed to live in my unit
   - ____ has never made regular contributions (payments, gifts, donations, etc.) to my household

7. I certify that I understand the following (*initial all*):
   - ____ Addition of a live-in aide must be approved by HRHA and the owner.
   - ____ My need for a live-in aide will be verified by a medical or care provider, including their understanding of the duration, level of care, and qualifications for care I require due to my medical condition or disability.
   - ____ A live-in aide must meet screening standards and pass a criminal background check prior to being approved.
   - ____ An approved live-in aide cannot add his/her family members to reside in the unit unless approved in writing by HRHA; has no rights to the voucher/unit and is not party to the lease; must abide by the terms of the lease and the program rules; qualifies for occupancy only as long as you require the specified care; cannot receive assistance or stay in the unit if role as live-in aide terminates (including if you move out or pass away); and may be terminated if found to be in violation of any of these rules & requirements.

8. I understand that for HRHA to process my request, my requested live-in aide ***must*** submit the following:
   - ☐ Social security card
   - ☐ Birth certificate
   - ☐ Photo ID
   - ☐ Release form
   - ☐ Live-in Aide Certification

   And *may* also be asked to submit:
   - ☐ Proof and/or certification of separate finances,
   - ☐ Documentation that the aide has or has left a prior residence in good standing

9. I authorize the following care provider to verify my condition or disability-related need for a live-in aide

Provider Name	Agency/Facility	
Title/Profession	Fax	Phone
Address		City, State, Zip

RELEASE / AUTHORIZATION

I authorize HRHA to contact the provider named above to verify my disability and/or medical need for an extra bedroom and/or live-in aide. I understand that this release is limited to information required to verify my request and that information obtained by HRHA will be kept confidential and used solely to make a determination on this request. I understand that I may submit supporting documentation directly to HRHA, and that HRHA will not seek details on the nature or severity of my disability.

I certify that the information provided on my request for a live-in aide and/or extra bedroom is true, correct and complete.

Head of Household Name	Head of Household Signature	Date

☐ Check here if parent/guardian signing on behalf of a minor child.

WARNING: Title 18, Section 1001 of U.S. Code states that a person is guilty of a felony for knowingly and willingly making a false or fraudulent statement to any department or agency of the United States Government.

I understand that this authorization is voluntary; I can withdraw permission at any time. I understand that HRHA is not a healthcare provider, and released information will be kept confidential but is not subject to HIPAA. I understand that I have the right to revoke this authorization, in writing, at any time by sending written notification to the releasing agency. Written revocation will be effective upon receipt, but will not apply to information already released in response to authorization. I understand that once my healthcare provider discloses my information to HRHA, they are no longer responsible for its privacy. I understand that I have a right to receive a copy of this authorization for my records. Copies of this release should be treated the same as an original.