



CERTIFICATION OF NEED FOR LIVE-IN AIDE

Name of person requiring live-in aide: _____

Current Address: _____

Please provide the following information for the medical professional or professional employed by a peer support group or non-medical service agency that will complete this form:

Name: _____

Address: _____

City, State, ZIP: _____

FAX #: _____

RELEASE

RELEASE: I hereby authorize the release of the requested information. Information obtained under this consent is limited to information that is no older than 12 months.

Signature of person requiring live-in aide: _____ Date: _____

Return to Roseville Housing Authority after completing top portion.

Form will be forwarded to the professional listed above.

To Whom It May Concern: Please complete the certification below and return by mail or fax to (916) 746-1295.

This information will be used only for the purpose of establishing our client's need for a live-in aide.

Date

Housing Technician

The following portion is to be completed by professional listed above

A Live-in Aide means a person who resides with one or more elderly or near-elderly persons or persons with disabilities, and who:

- (1) Is determined to be essential to the care and well-being of the persons;
(2) Is not obligated for the support of the persons; and
(3) Would not be living in the unit except to provide the necessary supportive services.

Please check one:

_____ This person's needs may be met by a part-time caregiver visiting the home.

OR

_____ This person requires a live-in aide as defined above.

Signed: _____

Date: _____

Professional Title: _____

Telephone: _____