

SPECIAL FEATURES UNIT / LIVE-IN CAREGIVER VERIFICATION

THIS SECTION TO BE COMPLETED BY MANAGEMENT AND EXECUTED BY APPLICANT/TENANT

This Verification is being delivered in connection with the undersigned's eligibility for residency in the following community:

Project Name: _____ Unit Number (if assigned): _____

By my signature, I hereby authorize disclosure of the information requested below in order to determine my eligibility to rent as required by Section 42 of the Internal Revenue Code.

Applicant/Tenant Signature

Return Form to:

Printed Name of Applicant/Tenant

Date

Date of Birth

THIS SECTION TO BE COMPLETED BY HEALTHCARE PROFESSIONAL OR CASE MANAGER

The above-named individual has applied for residency or is currently residing in housing that requires verification of the need of a special features unit and/or a live-in caregiver. The applicant/tenant has named you as the person who can verify his/her need(s). **This is NOT an inquiry as to the nature or severity of a handicap/disability. Your certification is simply needed to determine that the applicant/tenant does in fact need one or more of the elements described within this verification.** Please review and complete the information below, then return the form to the address or fax number listed above.

I duly state the following:

1. The person I am verifying the need for a special unit and/or live-in caregiver is:

_____, said person listed above.

2. **The special feature required by the above-named individual is:** (check all that apply)

- | | | |
|--|---|--|
| <input type="checkbox"/> Barrier-free unit | <input type="checkbox"/> One-level unit | <input type="checkbox"/> Unit for vision-impaired |
| <input type="checkbox"/> Unit for hearing impaired | <input type="checkbox"/> A separate bedroom | <input type="checkbox"/> Bedroom/bath on first floor |
| <input type="checkbox"/> Physical modifications to a standard unit | | |

The verification and explanation of the need(s) checked above is: _____

3. **The above-named individual requires the need for a live-in caregiver:** Yes No

The verification and explanation of "Yes" as checked above is: _____

I hereby certify that the information provided above is accurate and complete to the best of my knowledge. I consent to release such information in order to comply with government regulations regarding the Housing Credit Program. I understand that providing false or misleading information may subject me to criminal penalties. I fully understand the information requested and the ramifications of my breach of this agreement.

Signature of Healthcare Professional
or Case Manager

Printed Name of Healthcare Professional
or Case Manager

Date

Phone Number

NOTE: Section 1001 of Title 18 of the U. S. Code makes it a criminal offense to make willful false statements or misrepresentations to any Department or Agency of the United States as to any matter within its jurisdiction.