GAINESVILLE
Housing Authority
Where Housing Matters

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1900 SE 4th Street
Gainesville, Florida 32641

Pamela Davis, *Chief Executive Officer*

GainesvilleHousingAuthority.org

Requesting Approval for a Live-In Aide

State the purpose of your request: ☐ **First Request** ☐ **Annual Request**-*(504 Request for Live-In Aide previously approved)* ☐ **Changing Live-In Aide**

Request made by:

Name: _____ Phone #: _____

Address: _____

Please answer **the following** questions:

1. Which family member requires a live-in aide? _____
2. Explain how a live-in aide is essential to the care and well-being of this family member:
   _____
3. Is the live-in aide needed: ☐ Full-time ☐ Part-time
4. List any qualified health professionals who can verify the need for a live-in aide.

Name/Title: _____ Phone # _____

5. What is the current address of the proposed live-in aide?

_____

Street City/State Zip Code

6. What is the previous address of the proposed live-in aide?

_____

Street City/State Zip Code

7. How much will the live-in aide be paid? $_____ Per _____
8. Is the proposed live-in aide a relative? ☐ Yes ☐ No. If yes, how? _____

I certify that the information is true and accurate to my best knowledge and belief.

Signature:_____ Date: _____

WARNING! Title 18 Section 1001 of the United States Code, states that a person who knowingly and willingly makes a false or fraudulent statements to any department or agency of the United States is guilty of a felony.

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LIVE-IN AIDE CERTIFICATION

Head of Household Name: _____

I,_____, **the potential live-in aide**, do hereby certify that the following statements are true and correct.

1. I will reside in the above named resident's unit while performing the duties of live-in aide.
2. I am not obligated for the support of the elderly, handicapped or disabled family member named above.
3. I would not be living in the above named resident's unit except to provide care of the elderly, handicapped, or disabled family member.
4. I understand that my income will not be counted for the purpose of determining eligibility or rent.
5. I understand that I cannot be considered the remaining member of the tenant family in the event that the elderly, handicapped or disable family member is no longer a member of the family composition.
6. I hereby authorize Gainesville Housing Authority to conduct a background check for the purpose of verifying my eligibility for housing assistance. I understand that this may include, but is not limited to, criminal history and other relevant records as permitted by law. I further consent to the release of any information necessary to complete this verification process.

_____ _____
Signature of Live-In Aide Date

_____ _____
Print Name of Live-In Aide Date

Attach a copy of the following documents:
☐ Valid Picture ID ☐ Birth Certificate ☐ Social Security Card
Complete and sign the attached documents:
☐ Citizenship 214 Form (Complete, check the appropriate box, sign, and date).
☐ Authorization to Obtain Criminal Background Records

CITIZENSHIP CERTIFICATION

The U. S. Department of Immigration and Nationalization Act, Section 214

Notice to Applicants, Program Participants, and Tenants: *In order to be eligible to receive the housing assistance sought, each applicant for or recipient of housing assistance must be lawfully with the U.S.*

Please read the Declaration statement carefully and sign and return to the Housing Authority Admissions Office. Please feel free to consult with an immigration lawyer or other immigration expert of your choosing.

I, _____ certify under penalty of perjury, that, to the best of my knowledge: I am lawfully within the United States because (please check the appropriate box):

☐ I am a citizen by birth, a naturalized citizen or national of the United States

☐ I have eligible immigration status and I am 62 years of age or older. (Attach evidence of proof of age).

☐ I have eligible immigration status as checked below. Attach INS document(s) evidencing eligible immigration status and signed verification consent form.

- ☐ Permanent residence under section 249 of INA. ***(Alien Registration Receipt Card – Form I-551)***
- ☐ Amnesty under section 245A of the INA or Section 210. ***(Temporary Resident Card Form I-688 or Employment Authorization Card Form I-688B)***
- ☐ Refugee asylum, or conditional entry status under section 207, 208, or 243(h) of the INA. ***(Arrival-Departure – Form I-94)***
- ☐ Parole status under section 212 (d) (5) of the INA. ***(Arrival-Departure – Form I-94)***
- ☐ Threat to life or freedom under section 243 (h) of the INA. ***(Arrival-Departure – Form I-94)***

_____ _____

Signature of Family Member Date

☐ Check box on left if signature is of the adult residing in the unit who is responsible for the child named on the statement above.

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1900 SE. 4th St., Gainesville, FL 32641
Telephone (352) 872-5500 ~ Fax (352) 872-5501
www.gainesvillehousingauthority.org

EXECUTIVE DIRECTOR
PAMELA E. DAVIS

AUTHORIZATION TO OBTAIN CRIMINAL BACKGROUND RECORDS

I/We hereby consent to and authorize the Gainesville Housing Authority ("the Authority") to obtain any and all records concerning my/our criminal background, including but not limited to NCIC records, Florida Department of Law Enforcement records of and in any other State(s) in which I have lived, and the records of any State(s) sex offender registration, including the Florida Section Predator program.

This consent and authorization shall terminate upon termination of my/our tenancy under Public Housing or Section 8 Assistance by the Authority.

I/We consent to and authorize any law enforcement agency to release to the Authority my/our criminal background records, including any records of my/our arrest or conviction of any criminal offense under laws of any State in the Continental U.S or of any country.

_____

Print Name of Head of Household Date Signature

_____

Print Name of Other Adult Date Signature

_____

Print Name of Other Adult Date Signature

THIS SECTION FOR GHA STAFF ONLY

_____Reviewed on this date _____

_____Disposed on this date_____

_____Action Needed _____

_____Other notes_____

_____

_____

Signature of GHA Staff Date

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LIVE-IN AIDE MEDICAL VERIFICATION FORM

(For Reasonable Accommodation Determination – Housing Programs)

Applicant/Participant Name: _____ **Date of Birth:** _____

Medical Service Provider Name: _____
Professional Title: _____
Office Address: _____
Phone: _____ **Fax/Email:** _____

PURPOSE OF THIS FORM

The above-named individual has requested approval for a **live-in aide** as a reasonable accommodation. Housing regulations permit verification only of disability-related need for the accommodation. **Do not provide diagnosis or detailed medical records.** Only information related to functional limitations and necessity is required.

VERIFICATION QUESTIONS

Please check or complete all applicable items:

1. Does the patient have a physical, mental, or medical impairment that substantially limits one or more major life activities?
   ☐ **Yes** ☐ **No**
2. Is a live-in aide **medically necessary** for the patient's health, safety, or ability to live independently?
   ☐ **Yes** ☐ **No**
3. The patient requires assistance with:
   ☐ Activities of Daily Living (bathing, dressing, eating, toileting)
   ☐ Instrumental Activities (medications, transportation, housekeeping)
   ☐ Mobility/transfer assistance
   ☐ Monitoring for medical or safety needs
   ☐ Cognitive supervision
   ☐ Other: _____
4. Frequency of assistance required:
   ☐ Intermittent
   ☐ Daily
   ☐ Overnight supervision
   ☐ Continuous / 24-hour support

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5. Can the patient safely live alone without a live-in aide?
   ☐ **Yes** ☐ **No**
6. Is the presence of a live-in aide required rather than periodic caregiver visits?
   ☐ **Yes** ☐ **No**
7. Expected duration of need:
   ☐ Temporary — Estimated length: _____
   ☐ Long-term/Permanent
8. Without a live-in aide, would the patient's health, safety, or housing stability likely be at risk?
   ☐ **Yes** ☐ **No**

OPTIONAL FUNCTIONAL INFORMATION

(Only information relevant to housing accommodation)

MEDICAL SERVICE PROVIDER CERTIFICATION

I certify that I am a licensed medical or qualified health professional familiar with this patient's condition, and that the information provided is accurate to the best of my professional knowledge.

Printed Name: _____

Medical Service Provider Signature: _____ Date: _____

Florida Medical License Number: _____

Return completed form to:
Gainesville Housing Authority (Main Office): 1900 SE 4th Street, Gainesville, FL 32641
Email: docs@gnvha.org
Fax: 352-872-5524

Privacy Notice: This verification will be used solely to evaluate eligibility for a reasonable accommodation. It will be kept confidential in accordance with applicable privacy laws.

EQUAL HOUSING OPPORTUNITY