



CARE PROVIDER CERTIFICATION

LIVE-IN AIDE REQUEST / REASONABLE ACCOMMODATION

The person requesting a live-in aide, _____, has asked that you complete this certification regarding their request for a live-in aide: A release form authorizing you to provide this information is attached to this request.

- 1. What is your relationship to this person, and what qualifies you to make the assessments sought on this form? If you provide medical or other services to this person, please state how long you have done so and in what capacity.
2. This person is (check any that apply): [] elderly 62+ [] near elderly 50-61 [] disabled* [] N/A
3. What is the anticipated duration of the disability/circumstance for which the accommodation was requested?
4. Due to their elderly/disabled status, does this person require an aide to live in the unit to provide care and necessary supportive services?
5. Is a live-in aide necessary to allow the person equal access to use and enjoy their housing program/unit?
6. Describe the duration (long-term/short-term); daily hours (i.e., 24/7, overnight, etc.); level of care; and skill level or any necessary qualifications/training necessary for a live-in aide to adequately provide the necessary supportive services.
7. Please explain why a daily in-home worker is not equally effective as an accommodation.
8. Would you be willing to testify on the patient's behalf to the information provided on this form?

I certify that it is my professional opinion that the above-named person has a qualified disability that has a verifiable need for accommodation. I certify my professional opinion is in compliance with applicable laws, regulations, standard industry practices and licensing guidelines.

Signature _____ Name _____ Date _____
Address _____ Title _____ Phone _____

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.