MIAMI-DADE PUBLIC HOUSING AGENCY
LIVE-IN AIDE VERIFICATION FORM

NAME: ____ CLIENT #: ___________
(***Head of household (HOH)***)

ADDRESS:____

NAME: ____
(*Print name of household member for whom the Live-in Aide is requested*)

REQUESTED LIVE-IN AIDE INFORMATION:

NAME: ___________________________________ PHONE NUMBER: ___________________

ADDRESS: ____

PLEASE RETURN TO: __________________________________
(Name of MDPHA Employee)

_____________________________________ __________________________________
(Address of MDPHA Employee) (Phone/Fax of Employee)

DEFINITION OF PERSON WITH DISABILITIES

Under federal law, an individual is disabled if he/she has a physical or mental impairment that substantially limits one or more major life activities; has a record of such impairment; or is regarded as having such impairment.

The HOH named above has applied for, or is a participant in, a housing program provided by Miami-Dade Public Housing Agency (MDPHA). The HOH has requested a Live-in Aide and must obtain verification that the Live-in Aide is needed. Please answer the questions below and return the form to the MDPHA employee listed above.

INFORMATION REQUESTED

1. Is the Household Member disabled as defined above? [ ] YES [ ] NO

2. Is a live-in aide essential to the care and well-being of the Household Member?
   [ ] YES [ ] NO If yes, for how long? __________

3. If the response to question # 2 is "Yes", then please explain what the live-in aide would do that is essential to the Household Member's care and well-being.

   ____

   ____

4. Does the Household Member require a live-in aide on a temporary basis?
   [ ] YES [ ] NO

5. If the response to question # 4 is "Yes", please provide an estimate of the duration of time (in months and/or years) during which the live-in aide must provide services that are essential to the care and well-being of the Household Member.
   ____

6. Using the checklist below, indicate the activities of daily living (ADLs) with which the person requesting a live-in aide requires assistance and with which the live-in aide would provide assistance.

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CHECKLIST: ACTIVITIES OF DAILY LIVING WITH WHICH CLIENT REQUIRES ASSISTANCE	
ACTIVITIES OF DAILY LIVING (ADL) *(Check applicable)*	**CLIENT REQUIRES ASSISTANCE WITH THESE ADLs** **Y**= Yes (or) **N**= No *(Enter Y or N as applicable)*
☐ Walking	
☐ Standing	
☐ Sitting	
☐ Transfer to/from bed, chair/couch, bathtub and/or shower	
☐ Cooking/food preparation	
☐ Feeding him or herself	
☐ Drinking	
☐ Shopping	
☐ Housecleaning	
☐ Laundry	
☐ Bathing	
☐ Grooming	
☐ Dressing (clothes)	
☐ Taking medication	
☐ Application of wound dressings (changing/applying cloth or adhesive bandages, antiseptics, etc.)	
☐ Handling financial matters	
☐ Decision-making	
☐ Memory	
☐ Lifting	
☐ Reaching	
☐ Other (Please Specify in non-technical terms that simply describe the ADLs with which the client needs assistance)	

STATEMENT OF VERIFICATION SOURCE

I, ____ do hereby certify that the information provided
(Print Name)
above is correct and accurate to the best of my professional knowledge.

____ Date ____/____/____
(Signature)

Title of Verification Source: ____

Address: ____

Telephone: __________________________________**Fax:** _______________________________

Name of organization or company: ____

This form is available in an accessible format upon request. Please call the ADA Coordinator at (786) 469-4229 (phone) – Florida Relay Service (800) 955-8771 (TDD/TTY).