HEALTH AND HUMAN SERVICES AGENCY
HOUSING AND COMMUNITY DEVELOPMENT SERVICES
3989 RUFFIN ROAD, SAN DIEGO, CA 92123
(858) 694-4801 | FAX (858) 467-9713

CERTIFICATION OF NEED FOR LIVE-IN-AIDE

SECTION 1: PATIENT'S INFORMATION

Patient Name: _____ Patient's DOB: _____

Patient's Age: _____

SECTION 2: HUD DEFINITION OF DISABILITY AND DEFINITION OF LIVE-IN-AIDE

DEFINITION OF DISABILITY: Section 504 of the Rehabilitation Act of 1973 and Fair Housing Amendments define a "disability" as:

- A physical or mental impairment that substantially limits one or more major life activities;
- A record of such impairment; or
- Being regarded as having such an impairment.

DEFINITION OF A LIVE-IN-AIDE: A person who resides in the unit to provide necessary supportive services for a member of the family who is a person with disabilities.

- Essential to the care and well-being of that person;
- Not legally obligated to provide support to that person;
- Would not be living in the unit except to provide supportive services.

SECTION 3: HEALTHCARE PROFESSIONAL'S CERTIFICATION OF NEED FOR ACCOMMODATION

Dear State of California licensed medical or social service professionals:

The above-named patient has been approved for participation in the Section 8 Rental Assistance program and has reported to us that because of the nature of his/her disability, a live-in-aide is required. We ask that you review this patient's request and verify in your professional opinion, the existence of an impairment that substantiates the Reasonable Accommodation request. To help us make a determination, we would appreciate your evaluation based on your knowledge of the unique needs of your patient. **Please write legibly**.

Thank you for your cooperation on behalf of your patient. **If this form is not answered completely or answers are not legible the request will be denied.**

1. Is it in your opinion that because of the nature of your patient's disability he/she requires the assistance of a live-in-aide?

☐ Yes ☐ No

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2. If you answered "Yes" above, please give us an idea how long the need will last.
   - ☐ TEMPORARY (less than 12 months)
     If temporary, what is the approximate duration? _____
   - ☐ PERMANENT (more than 12 months)

3. The following are Major Life Activities as defined by Section 504 of the Rehabilitation Act of 1973 and Fair Housing Amendments:

   ☐ Walking ☐ Speaking ☐ Hearing ☐ Seeing
   ☐ Breathing ☐ Working ☐ Learning ☐ Self-Care
   ☐ Performing Manual Task

4. Please explain why a live-in-aide is necessary to provide this vital care to the patient **that <u>cannot be performed in</u>** any other way (e.g., by day caregiver, other family member. Etc.): Do Not list diseases.

_____

_____

_____

_____

_____

I certify that it is my firm ***professional opinion*** that the above-named party has a serious medical condition that indicates a ***direct and verifiable*** need for a bedroom for a live-in-aide**.** I further certify my professional opinion is in compliance with all applicable laws, regulations, standard industry practices and licensing guidelines**.** ***(Please print the information below)***

Professional's Name: _____ Professional's License No: _____

Address: _____ Phone No: _____
Street City State Zip Code

Professional's Signature: _____ Date: _____