Request for Live-in Aide AND Request to Change Live-in Aide

If this is a <u>new request</u> for a live-in aide, <u>complete the entire form</u>, Section I and II.

If you have <u>already been approved</u> for a live-in aide and are requesting permission to <u>add a new live-in aide</u> to your household composition, <u>complete Section II only</u>.

Section I

1. Voucher Family Member for whom the live-in aide is being requested: _____

Voucher Head of Household: _____

The Housing Authority of the County of Santa Cruz may approve a request for a live-in aide as a reasonable accommodation for a person with disabilities. In order for your request to be considered you must supply the following information:

2. The family member's doctor, or other health care professional or social worker with medical or professional knowledge of the disability will be contacted to verify the need for a live in aide. Please list the name of the qualified professional who can verify the disability and the need for the accommodation requested.

→ **<u>If you include contact information that is incomplete or incorrect, this form will be returned to you to complete and/or correct, which will delay the processing of your request.</u>**

Name: _____ Hospital, Clinic or Office: _____

Complete Mailing Address: _____ Phone: _____

City: _____ State: _____ Zip Code: _____ Fax: _____

The Housing Authority may contact the health care professional or social worker directly to verify the need for a live-in aide, if such verification is not already on file.

Authorization to Release Information: I authorize the health care provider or social worker listed above to disclose relevant information to the Housing Authority of the County of Santa Cruz regarding the need for a reasonable accommodation. I understand the information the Housing Authority obtains will be kept confidential and used solely to determine if an accommodation should be provided.

You will be informed of the Housing Authority's granting, denial or status of this request within thirty (30) days of the receipt of this request.

Section II

3. Name of proposed live-in aide:_____ DOB:_____ SSN:_____

Current street address:_____ City: _____ Phone:_____

Is the live-in aide related to any family member? If so, describe: _____

4. Live-in aide's family members, if any, who will also be living in your unit with the live-in aide:

Name	Relationship	Age	SSN

No action will be taken until you return this form completed, to the Housing Authority of the County of Santa Cruz, 2160 41st Avenue, Capitola, CA 95010. If you have any questions regarding this, please contact the Housing Authority at (831) 454-5955 Monday through Thursday, between 8:00 AM – 4:45 PM