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750 Commerce Drive
Suite 201
Decatur, Georgia 30030



Certification of Need for Attendant Care/Auxiliary Apparatus

Applicant/Participant Name _____

Tenant ID _____

Requesting Household Member _____

This person has applied for housing assistance under a program of the U.S. Department of Housing and Urban Development (HUD). HUD requires the housing agency to verify all information that is used in determining this person's eligibility or level of benefits.

We ask your cooperation in providing the following information and returning it to the person listed at the top of the page. Your prompt return of this information will help to ensure timely processing of the application for assistance. The applicant/tenant has consented to this release of information as shown above.

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INFORMATION BEING REQUESTED

For each numbered item below, mark an "X" or "✓" in the applicable box that accurately describes the person listed above.

- 1. ___ YES ___ NO Does the above person have a disability related need for a Live-in Aide/Attendant?
- 2. ___ YES ___ NO Is the Live-in Aide/Attendant essential to the care and well-being of the person?
- 3. ___ YES ___ NO Does the applicant/tenant require a separate bedroom for medical apparatus or other medically related purpose?

Name and Title of Person Supplying Information (Please Print)

Signature of Name and Title of Person Supplying Information

Firm/Organization Name

Firm/Organization Current Address, City, State & Zip Code

Telephone Number (Office)

Telephone Number (Fax)

Email Address (Office)

Do Not Write In This Space for Official HADC Use Only

Date Verification 1 st Attempted: _____	Verified: _____	Request Approved: _____	Request Denied: _____
Date Verification 2 nd Attempted: _____	Verified: _____		
Date Verification 3 rd Attempted: _____	Verified: _____	Date Request Forwarded to Specialist: _____	