

REQUEST TO ADD LIVE-IN AIDE

The Housing Authority of Prince George's County ("HAPGC) must grant approval before a Live-in Aide may reside in a subsidized unit.

DEFINITION OF LIVE-IN AIDE, HUD (CFR SECTION 5.403):

A person who resides with one or more elderly persons, near-elderly persons, or persons with disabilities, and who:

1. Is determined to be essential to the care and well-being of the person(s);
2. Is not obligated for the financial support of the persons(s); and
3. Would not be living in the unit except to provide the necessary supportive services.

This form is not for aides who come and go, such as occasional, intermittent, multiple, or rotating caregivers that work specific shifts during the day or night or who occasionally spend the night.

PURPOSE OF LIVE-IN AIDE: A Live-In Aide is permitted by HAPGC and the landlord to occupy the client's unit to assist the disabled family member with services to successfully live in the premises, perform daily living activities, and meet the lease terms. If the client no longer needs the services of the Live-in Aide, the client must inform HAPGC and the landlord of the change. The unit will be downsized to the appropriate occupancy standard.

BACKGROUND SCREENING: Tenant and the proposed Live-In Aide agree to provide HAPGC and the Landlord with all information necessary for screening to determine whether the aide meets reasonable occupancy criteria. The proposed live-aide may be denied if they do not meet the requirements. HAPGC may refuse to approve a live-in aide if (1) the person commits fraud, bribery or any other corrupt or criminal acts in connection with any Federal housing programs; (2) the person commits drug related or violent criminal activities; or (3) the person currently owes rent or other amounts to HAPGC or any other PHA in connection with the voucher program or public housing assistance.

LIVE-IN AIDE HAS NO RIGHTS OF OCCUPANCY: The Live-In Aide qualifies for occupancy only as long as the client needs supportive services. The Live-in Aide is not entitled or eligible for any rental assistance or continued occupancy after the services are no longer needed even if Live-in Aide is a family member of the client. A household member listed on a current lease cannot be a Live-In Aide, except if the occupant waives all their rights to the unit as a remaining household member if anything happens to the head of household.

Please note that you can ask for a reasonable accommodation to use HAPGC housing or services. This can include auxiliary aids or services, materials in an alternative format, or help in completing paperwork or changes to your housing based on your disability. Contact the 504 Coordinator at (301)883-5576 or email dhcd-504@co.pg.md.us for assistance.



HAPGC will allow one additional bedroom for occupancy by and approved Live-In Aide. However, HAPGC will deny approval of the Live-in Aide if the presence of the Live-In Aide’s family will overcrowd the unit or property resulting in violation of HUD Housing Quality Standards.

RECERTIFICATION OF THE TENANT’S NEED FOR THE LIVE-IN AIDE: HAPGC has the right to recertify the continued occupancy of the live-in aide along with the client’s annual recertification. Upon request, the client agrees to provide HAPGC with necessary information required.

I have read, understand, and agree to comply with the terms, rules, and regulations as it relates to the addition of a Live-in Aide for supportive services in a subsidized housing program.

Head of Household Signature: _____ Date: _____

PART I: TO BE COMPLETED BY FAMILY

Head of Household (print) _____

Last 4 Digits of SSN XXX -XX -

Address _____

Current unit/allocation size _____

Total number of additional occupants, including the Live-in Aide, being requested to add _____

Number of adults _____ Number of children _____

I understand that the actions of my Live-in Aide and/or any other guest in my home are my responsibility. I also understand that if their actions are a breach of the lease or program requirements, that their actions could result in my lease and housing assistance being terminated. In addition I understand that if I no longer need a Live-in Aide or if my current Live-in Aide no longer resides in the unit, I must report this change to HAPGC within 10 business days.

Signature of Head of Household _____ Date _____

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PART II: TO BE COMPLETED BY LIVE-IN AIDE

Live-in Aide Name _____

SSN _____

DOB _____ Race _____ Ethnicity: Hispanic or Non-Hispanic (*circle one*)

Gender: Male or Female (*circle one*)

1. Have you ever lived in subsidized housing?

YES NO

If yes, where and when? _____

2. If yes, do you owe money to a housing authority?

YES NO

3. Have you been evicted for drug or criminal activity in the last three years?

YES NO

4. Are you a US citizen?

YES NO

5. Are you required to register as a sex offender in any state? If “yes”, provide state name

YES NO

6. Have you been incarcerated or under parole/probation or arrested in the last 5 years?

YES NO

7. Are you employed?

YES NO

If you have answered yes to question 7, fill out your employment info below:

Place of Employment _____

Employment Address/Location _____

Employment HR Phone Number _____

Employment HR Fax Number _____

Present Position _____

Current Base Pay _____ per _____ (hour, week, month, year, bi-wk, bi-mo)

What day/days do you work? (*Circle*) Monday Tuesday Wednesday Thursday Friday Saturday Sunday

How many hours do you work during the week? _____

What Shift do you work? (*Circle*) Morning Evenings Nights

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If you answered no to question number 7, fill out a zero income statement.

I understand that my eligibility as a Live-in Aide in a federally funded housing program is dependent on the results of eligibility. My signature below not only certifies that the information provided on this form is true and complete but also authorizes HAPGC to conduct such check. In addition, I understand that I would not be living in the unit except to provide the necessary supportive services and have no rights to the subsidized housing unit or rental subsidy.

Signature of Live-in Aide _____
Date _____

PART III: TO BE COMPLETED BY THIRD PARTY PROVIDER

**VERIFICATION OF NEED FOR A
REASONABLE ACCOMMODATION OF A LIVE-IN AIDE**

Applicant's Name: _____

Household Member requesting Live-In aide: _____

Address: _____

I, _____, authorize the release of information requested below.

Signature of Applicant or Guardian: _____ Date: _____

Name: _____ Professional Lic. # (if applicable): _____

Company or Agency Name (if applicable): _____

Address: _____

Phone #: _____ Fax#: _____ Email: _____

The individual is requesting the assistance of a live-in aide related to a disability. This is not verification for aides who come and go, such as occasional, intermittent, multiple or rotating caregivers that work specific shifts during the day or night or who occasionally spend the night.

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A live-in aide must meet the HUD definition: *A person who resides with one or more elderly persons, near-elderly persons, or persons with disabilities, and who:*

- (1) Is determined to be essential to the care and well-being of the person(s);
- (2) Is not obligated for the financial support of the person(s); and
- (3) Would not be living in the unit except to provide the necessary supportive services.

CLIENT INFORMATION

1. The Fair Housing Act defines a person with a disability as (1) individuals with a physical or mental impairment that substantially limits one or more major life activities; (2) individuals who are regarded as having such an impairment; and (3) individuals with a record of such an impairment.

In your opinion, does the applicant have a physical, medical, mental or psychological impairment or history/record of such impairment that requires accommodation:

___ YES ___ NO ___ UNKNOWN

2. If applicable, please explain which major life activities may be affected by the disability or impairment:

3. Is the impairment permanent? ___ YES ___ NO ___ UNKNOWN

4. If “yes”, how if the accommodation of the need for a live-in aide linked to the persons impairment? Please specify the nature of the assistance. (Note: in order for the accommodation to be considered, a connection must be made between the impairment and the requested accommodation. You do not have to disclose the actual diagnosis or the severity of the impairment.):

If the impairment is temporary or if you are not sure of how long the applicant will be impaired, please explain why the live-in aide assistance is necessary, and how long the assistance is needed:

I hereby certify, under the penalty of perjury, that the information provided in this health verification (including any accompanying statements or forms) is true and correct. False or fraudulent statements will be subject to the penalties provided by law.

Signature of third party verifier: _____ Date signed _____

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Please promptly return the completed form Attn: Fair Housing Coordinator at 9200 Basil Court, Suite 500, Largo, Maryland 20774. This form may also be faxed to 301-883-9832 or submitted by email DHCD-504@co.pg.md.us. Final decisions are made within 45 days of less, after receipt of all requested documents.

If you have questions regarding this form, please submit your inquiry via email to DHCD-504@co.pg.md.us, or contact 301-883-5576 or mail to Housing Authority of Prince George's County, 9200 Basil Court, Suite 500, Largo, Maryland 20774.

PART IV: TO BE COMPLETED BY HAPGC

(HOH must be provided a copy of page one of this application)

Approved Denied

Reason for Denial _____

HAPGC Staff Signature _____

Date _____

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