LIVE-IN CARE ATTENDANT AFFIDAVIT

RETURN TO:_____ **DATE:**_____ **APT. #:**_____

_____ **DEVELOPMENT NAME:**_____

TEL.#:_____ **APPLICANT/RESIDENT:**_____

FAX #:_____ _____

I duly state the following:

1. I am/will be residing with_____

2. I am **ESSENTIAL** to the care and well-being of said person.
   Please provide verification of need by said person's health care professional or case manager.

3. I am **NOT** obligated or responsible for the financial support of said person.

4. I would not otherwise be living in the unit **EXCEPT** to provide the necessary supportive care services for said person.

5. I understand that I have no rights to the apartment that will be/is rented to said person. However, I understand that I must abide by the lease agreement signed by the said person. If said person vacates the residence for **ANY REASON** I will vacate premises as well. I understand that if I would like to occupy an apartment, I will be required to complete the Certification Process on my own record.

I hereby certify that the information provided above is accurate and complete to the best of my knowledge. I consent to release such information in order to comply with government regulations regarding allocation of tax credit housing. I understand that providing false or misleading information under oath may subject me to criminal penalties. I fully understand the information requested and the ramifications of my breach of this agreement.

_____ _____

Signature of Live-In Care Attendant — Date

Subscribed and sworn to before me under oath this _____ day of _____, Year _____

_____

Signature of Notary Public

Notary Public, State of _____ My commission expires _____, Year _____

OFFICE USE ONLY: