VERIFICATION OF CARE ATTENDANT
(RD)

This will authorize ___________________________(name of care provider) to release the information requested below regarding my expenses for the care of a disabled/handicapped family household member.

Full Name (please print or type)	Social Security Number
Signature	Street Address
Date	City, State, Zip

TO WHOM IT MAY CONCERN:

The family/individual named above is a resident/applicant for housing which has rents that are subsidized through Rural Development. Federal regulations require that in order for a family to be eligible for this form of assistance, the income of the family, as well as its assets must not exceed certain established limits. The information requested below will be held in strict confidence and will be used only to determine the eligibility of the family for the housing subsidy.

Since we cannot approve this family/individual for the Program until this information is received, we would appreciate your cooperation and prompt attention in completing those applicable portions of this inquiry and returning it in the enclosed, self-addressed envelope.

Sincerely,

____
Position/Title

____
Development

____
Address

____
Telephone Number

It is anticipated that over the next twelve months, I will provide care for___________________________ (Name of disabled/handicapped person), as follows:

Rate of pay per ( ) Hour, ( ) Week, ( ) Month: $____________________
Anticipated total pay to be received over the next 12 months: $____________________

Signature of Care Attendant	Address
Telephone Number	Date

12/01