GEORGIA HOUSING VOUCHER PROGRAM
GHVP-17: Certification of Need for Extra Bedroom or Live-In Aide
This form must be submitted at the time of the initial referral to DBHDD if applicable or when circumstances warrant to request a live-in aide or extra bedroom.

GHVP Client Name

Household Member Requesting Live-In Aide (*if different from client*)

Name of Live-In Aide

Relationship of Live-In Aide to Tenant

Instructions*: The following portion of the form needs to be completed by a physician, psychiatrist, or other medical practitioner or health care provider that is working with the patient requesting a live-in aide. Supporting documentation must be provided which outlines the medical necessity in addition to this executed form.*

Dear Health Care Professional:

Your patient identified above has reported that they have a medical condition that requires a live-in aide and a bedroom for the aide's exclusive use. A live-in aide is defined as a person who has been determined to be essential to the care and wellbeing of your patient and must meet the below criteria:

A live-in aide:
- must provide essential care to or for the tenant,
- must not be obligated to support the tenant (i.e. spouse or dependent), and,
- wouldn't otherwise live in the unit except to provide essential care for the tenant.

To help us make a determination on this need, we would appreciate your evaluation based upon your knowledge of the patient's medical condition as well as with the individual identified as the live-in aide.

1. **Is it your opinion that because of the patient's medical condition that they require the assistance of a live-in aide and will require an additional bedroom for the exclusive use by the live-in aide?**

   Yes ◯ No ◯

2. **Please identify how long the need is expected to last:**

   Temporary (*less than 12 months*) ◯ Permanent (*more than 12 months*) ◯

3. **Is it your opinion that the individual named above is able to serve as a live-in aide for the patient?**

   Yes ◯ No ◯

I certify that it is my firm professional opinion that the above named individual requesting a live-in aide has a serious medical condition that indicates a *direct and verifiable* need for additional state funds for an extra bedroom for use by the live-in aide. I further certify my professional opinion is in compliance with all applicable laws, regulations, standard industry practices and licensing guidelines.

Professional License No. | Professional's Name (Print) | Phone Number

Licensed Professional Signature | Date

Work Contact Address | Work City/State/ZIP