MEDICAL EXPENSE VERIFICATION

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

_____ **DEVELOPMENT NAME:** _____

_____ **RE:** _____

TEL.#: _____

FROM: _____

_____

TEL.#: _____ **FAX #:** _____

In order to comply with federal regulations requesting verification on all income, assets and allowances for residents of tax credit housing, please complete the following information and return it as soon as possible to the above address.

All medical expenses, which are described below may be listed as allowances to help reduce my rental cost.

I hereby authorize release of any information requested regarding my income, assets, and allowances.

_____ _____

Applicant/Resident Signature | Social Security Number

TO BE COMPLETED BY THE HOSPITAL/CLINIC/PHARMACY/ETC. WHERE EXPENSES ARE INCURRED:

SERVICES PROVIDED	MONTHLY COST	ANTICIPATED DURATION OF TREATMENT	YTD EXPENSES PAID BY PATIENT

Are any of these expenses paid by insurance? ☐ **YES** ☐ **NO**

Which expenses? _____ Insurance Co.: _____

Does the applicant have outstanding bills that are still being paid? ☐ **YES** ☐ **NO**

If yes, payment per month is? _____

COMMENTS: _____

_____

_____ _____

Signature of Person Verifying Information | Telephone Number

_____ _____

Title | Date

OFFICE USE ONLY:

EQUAL HOUSING OPPORTUNITY

We encourage and support the nation's affirmative housing program in which there are no barriers to obtaining housing because of race, color, religion, sex, national origin, handicap or familial status.