

## VERIFICATION OF MEDICAL EXPENSES

(03/20)

Date				
Please Return To	Address	City	State	ZIP Code
Regarding: Name				
Address		City	State	ZIP Code

This person has applied for housing assistance under a program of the U.S. Department of Housing and Urban Development (HUD). HUD requires the housing owner to verify all information that is used in determining this person's eligibility or level of benefits. We ask your cooperation in providing the following information and returning it to the person listed at the top of the page. Your prompt return of this information will help to assure timely processing of the application for assistance. Enclosed is a self-addressed, stamped envelope for this purpose.

### TO BE COMPLETED BY APPLICANT

I hereby authorize the above named management agent to make inquiries regarding my Medical Expenses for the purpose of determining my eligibility for occupancy. The applicant or tenant may not sign the consent if the form does not clearly indicate who will provide the requested information and who will receive the information. **This consent form is valid for 15 months from the date it is signed.**

### PENALTIES FOR MISUSING THIS CONSENT

Title 18, Section 1001 of the U.S. Code states that a person is guilty of a felony for knowingly and willingly making false or fraudulent statements to any department of the United States Government. HUD and any owner (or any employee of HUD or the owner) may be subject to penalties for unauthorized disclosures or improper uses of information collected based on the consent form. Use of the information collected based on this verification form is restricted to the purposes cited above. Any person who knowingly or willingly requests, obtains, or discloses any information under false pretenses concerning an applicant or participant may be subject to a misdemeanor and fined not more than \$5,000. Any applicant or participant affected by negligent disclosure of information may bring civil action for damages and seek other relief, as may be appropriate, against the officer or employee of HUD or the owner responsible for the unauthorized disclosure or improper use. Penalty provisions for misusing the social security number are contained in the Social Security Act at 208 (a) (6), (7) and (8). Violations of these provisions are cited as violations of 42 USC 408 (a), (6), (7) and (8).

Signature	Date
-----------	------

### INFORMATION BEING REQUESTED

**\* If submitting a printout please exclude the names of doctors and medications. The print out must indicate "out of pocket" expenses for the party or parties listed above and be signed by the pharmacist.**

☐ Total **out of pocket** expenses paid by the party listed above for **Prescription Medication\*** during the **12** month period beginning \_\_\_\_\_ and ending \_\_\_\_\_. \$ \_\_\_\_\_

☐ Total **out of pocket** expenses paid by the party listed above for **Medical Expenses** during the **12** month period beginning \_\_\_\_\_ and ending \_\_\_\_\_. \$ \_\_\_\_\_

☐ Total **out of pocket** premiums expected to be paid by the party listed above for ☐ **Medical Insurance** or ☐ **Long Term Care Insurance** during the **next 12** months. \$ \_\_\_\_\_

☐ Other: \_\_\_\_\_ \$ \_\_\_\_\_

Name of Person Supplying Information	Title
Signature	Date