SAMPLE VERIFICATION OF ITEMIZED LIST OF OVER-THE COUNTER MEDICATIONS

Date: _____

Property Name:		**Property Address:**	
Telephone:		**Address 2:**	
Fax:		**TTD/TTY:**	

TO:

Name	
Address:	
City, State, Zip:	

Re: Resident/ Applicant

Name:	
Address:	
City, State, Zip:	
SSN:	
Unit:	

(Please return this form to the above address)

HOUSEHOLD MEMBER RELEASE

TO THE HOUSEHOLD MEMBER:

YOU DO NOT HAVE TO SIGN THIS FORM IF THE NAME OR ADDRESS OF EITHER THE PROJECT OR ADULT AND FAMILY SERVICES OFFICE IS LEFT BLANK.

RELEASE: I hereby authorize the release of the requested information. Information obtained under this consent is limited to information that is no older than 12 months. There are circumstances which would require the owner to verify information that is up to 5 years old, which would be authorized by me on a separate consent attached to a copy of this consent.

Signature _____ Date _____

We are required to verify out-of-pocket medical expenses to determine the amount of housing assistance provided to the household. We ask your cooperation in supplying the requested information listed below.

Signed _____ (Property Representative)

PLEASE COMPLETE THE FOLLOWING:

In accordance with HUD Handbook 4350.3 Revision 1, Change 2, out of pocket medical expenses can be used to reduce the annual income for the household. Please indicate if the over the counter purchases indicated are recommended by you to address a specific medical condition.

EQUAL HOUSING OPPORTUNITY

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RECEIPTS ARE REQUIRED FOR NON-PRESCRIPTION ITEMS

Name of Non-Prescription Item	Recommended – Yes or No	Dosage	Daily Weekly Monthly	To Treat a Specific Medical Conditon or for General Good Health
1.	☐ Yes ☐ No		☐ D ☐ W ☐ M	☐ Treat Cond ☐ Good Health
2.	☐ Yes ☐ No		☐ D ☐ W ☐ M	☐ Treat Cond ☐ Good Health
3.	☐ Yes ☐ No		☐ D ☐ W ☐ M	☐ Treat Cond ☐ Good Health
4.	☐ Yes ☐ No		☐ D ☐ W ☐ M	☐ Treat Cond ☐ Good Health
5.	☐ Yes ☐ No		☐ D ☐ W ☐ M	☐ Treat Cond ☐ Good Health
6.	☐ Yes ☐ No		☐ D ☐ W ☐ M	☐ Treat Cond ☐ Good Health
7.	☐ Yes ☐ No		☐ D ☐ W ☐ M	☐ Treat Cond ☐ Good Health
8.	☐ Yes ☐ No		☐ D ☐ W ☐ M	☐ Treat Cond ☐ Good Health

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Name of Non-Prescription Item	Recommended – Yes or No	Dosage	Daily Weekly Monthly	To Treat a Specific Medical Conditon or for General Good Health
9.	☐ Yes ☐ No		☐ D ☐ W ☐ M	☐ Treat Cond ☐ Good Health
10.	☐ Yes ☐ No		☐ D ☐ W ☐ M	☐ Treat Cond ☐ Good Health
11.	☐ Yes ☐ No		☐ D ☐ W ☐ M	☐ Treat Cond ☐ Good Health
12.	☐ Yes ☐ No		☐ D ☐ W ☐ M	☐ Treat Cond ☐ Good Health
13.	☐ Yes ☐ No		☐ D ☐ W ☐ M	☐ Treat Cond ☐ Good Health
14.	☐ Yes ☐ No		☐ D ☐ W ☐ M	☐ Treat Cond ☐ Good Health
15.	☐ Yes ☐ No		☐ D ☐ W ☐ M	☐ Treat Cond ☐ Good Health
16.	☐ Yes ☐ No		☐ D ☐ W ☐ M	☐ Treat Cond ☐ Good Health
17.	☐ Yes ☐ No		☐ D ☐ W ☐ M	☐ Treat Cond ☐ Good Health

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PENALTIES FOR MISUSING THIS FORM

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, the PHA and any owner (or any employee of HUD, the PHA 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 willfully 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, the PHA 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). Violation of these provisions are cited as violations of 42 U.S.C. 408 (a) (6), (7) and (8).

I understand the provisions provided in Title 18 above. I certify that I am currently licensed to prescribe medicine in the state of YOUR STATE and that the information provided on this form is true and correct.

_____	_____
Signature	Name and Title Health Care Provider
_____	_____
Company	Address/City/State/Zip
_____	_____
Telephone Number	Date

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