

MEDICAL EXPENSE VERIFICATION FORM

Name of Medical Professional: _____

PLEASE RETURN FORM TO:

Address: _____

SUBJECT: Verification of Information Supplied by an Applicant/Tenant for Housing Assistance

NAME: _____

ADDRESS: _____

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 ensure timely processing of the application for assistance. The applicant/tenant has consented to this release of information as shown below.

We are requesting information for the 12- month period of _____ to _____.

**Area to be completed by Medical Care Professional
(Please answer all questions. Answer N/A if the question doesn't apply.)**

Total amount of actual out of pocket medical expenses, not covered by insurance, paid in the 12- month period listed above:
\$ _____

Does the above-named Applicant/Tenant owe you an outstanding balance that the individual listed above is making payment on a payment plan: _____ Yes _____ No If yes, what is the current balance: \$ _____

What is the amount regularly paid: \$ _____ per _____.

Name and Title of Person Supplying the Information

Firm/Organization Name

Signature

Date

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 that would required 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

NOTE TO APPLICANT/TENANT: You do not have to sign this form if either the requesting organization or the organization supplying the information is left blank.

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 U.S.C. 408 (a) (6), (7) and (8).

Please return the form to the address listed above. Thank You.



Acceptable forms of Medical Expense Verification:

NOTE: HUD accepts three methods of verification. These are, in order of acceptability, third-party verification, review of documents, and family certification. If third-party verification is not available, owners must document the tenant file to explain why third-party verification was not available.

Medical expenses are not allowable as deductions unless applicant is an elderly or disabled family. Status must be verified.

1. Written verification by a doctor, hospital or clinic personnel, dentist, pharmacist, etc., of:
 - a. The estimated medical costs to be incurred by the applicant and of regular payments due on medical bills;
 - b. The extent to which those expenses will be reimbursed by insurance or a government agency; and
 - c. Whether the provider accepts Medicare assignment.
2. The insurance company's or employers written confirmation of health insurance premiums to be paid by the applicant.
3. Social Security Administration's written confirmation of Medicare premiums to be paid by the applicant over the next 12 months.
4. For attendant care:
 - a. Doctor's certification that the assistance of an attendant is medically necessary;
 - b. Attendant's written confirmation of hours of care provided and amount and frequency of payments received from the family (or copies of cancelled checks the family used to make those payments); and
 - c. Applicant's certification as to whether any of those payments have been or will be reimbursed by outside sources.
5. Receipts, cancelled checks, or pay stubs that indicate health insurance premium costs, etc., that verify medical and insurance expenses likely to be incurred in the next 12 months. The tenant file should also contain third party documentation verifying what type of insurance and the person covered under the insurance plan.
6. Copies of payment agreements with medical facilities or cancelled checks that verify payments made on outstanding medical bills that will continue over all or part of the next 12 months.
7. Receipts or other record of medical expenses incurred during the past 12 months that can be used to anticipate future medical expenses. Owners may use this approach for "general medical expenses" such as non-prescription drugs and regular visits to doctors or dentists, but not for one-time, nonrecurring expenses from the previous year.