



HOUSING AUTHORITY OF THE CITY OF BASTROP

PO Box 707(mailing), 502 Farm Street (physical), Bastrop, TX 78602

PH: 512-321-3398 TTY: 1-800-735-2989 FAX: 512-303-0568

The Owner does not discriminate against persons with disabilities

VERIFICATION OF MEDICAL EXPENSES

(HOSPITAL, CLINIC, PHYSICIAN, DENTIST, ETC)

To:

Date: _____

RE: _____

Address: _____

SSN: _____ DOB _____

The Housing Authority of the City of Bastrop is a federally funded agency assisting qualified families with rent subsidies. The above-named person is an applicant for, or a participant in, a federally-assisted housing program operated by the Housing Authority. In order to determine his/her eligibility and rent payment, we are required to verify the medical expenses the person named above anticipates for the coming (12) months that are NOT COVERED BY ANY MEDICAL INSURANCE. Please complete this form and return it as soon as possible. Thank you for your assistance.

Housing Authority Representative: _____

I do hereby authorize the release of all information requested below to the Housing Authority for the purpose of determining my eligibility for housing assistance.

Signature: _____

WARNING: 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 the unauthorized disclosures or improper use 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 \$5000.00. Any applicant or participant affected by negligent disclosure or 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), U.S.C. 408 (a) (6), (7) and (8). Violation of these provisions are cited as violations of 42 U.S.C. 408 (a) (6), (7) and (8).

This is to certify that the person named above:

(i) anticipates out-of-pocket medical expenses in the coming twelve (12) months of

\$ _____ *****or*****

(ii) has incurred out-of-pocket medical expenses in the past twelve (12) months of

\$ _____

Physician's Name: _____ Title _____

Representative's Signature: _____ Phone (____) _____ Date _____

If mailing address is missing or different than above, please provide:

Business Name: _____ Mailing Address: _____

City: _____ State: _____ Zip Code: _____