**MEDICAL EXPENSE VERIFICATION**

**(RD)**

**Applicant/Resident:**

**Social Security Number:**

**Due to Federal Regulations governing occupancy at this complex, we request written verification of the amount of medical expenses that is anticipated for the coming 12 months that is NOT COVERED BY MEDICAL INSURANCE/MEDICAID for the above referenced applicant/resident. If you are unable to determine the anticipated amount please provide us with what the applicant/resident spent last year NOT COVERED BY MEDICAL INSURANCE/MEDICAID.**

**Thank you for your cooperation.**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Signature of Manager Date**

**I hereby give my permission for the requested information to be released to**

**Apartments.**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Signature of Applicant/Resident Date**

1. **Name of Doctor, Clinic, Etc. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**
2. **Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

1. **Anticipated Amount of Medical Expenses which would include medical treatment,office**

 **visits, etc.**

 **(AMOUNT NOT COVERED BY MEDICAL INSURANCE/MEDICAID) $\_\_\_\_\_\_\_\_\_\_\_**

**4. If unable to determine anticipated amount, what was last years amount.**

**(AMOUNT NOT COVERED BY MEDICAL INSURANCE/MEDICAID) $\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 **Signature of Doctor Date**

**This institution is an equal opportunity provider and employer”**

 **EQUAL HOUSING OPPORTUNITY Revised 12/01**

