**Medicare – D Prescription Drug Plan**

Medicare D Prescription Drug Plan has been implemented and as part of your household certification and re-certification, we must determine if you participate. Please complete and sign the next section of this form.

Household Member’s Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Site Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Unit # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you a Medicare-D Prescription Drug Plan Participant? \_\_\_\_\_\_\_\_\_ Yes \_\_\_\_\_\_\_\_\_\_ No

Cost Per Month \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you a participant of another prescription drug plan? \_\_\_\_\_\_\_\_\_\_ Yes \_\_\_\_\_\_ No

If so, what plan? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Cost per month \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Tenant Signature Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Co Tenant Date

***If you wish to file a Civil Rights program complaint of discrimination, complete the USDA Program Discrimination Complaint Form, found online at*** [***http://www.ascr.usda.gov/complaint\_filing\_cust.html***](http://www.ascr.usda.gov/complaint_filing_cust.html)***, or at any USDA office, or call (866) 632-9992 to request the form. You may also write a letter containing all of the information requested in the form. Send your completed complaint form or letter to us by mail at U.S. Department of Agriculture, Director, Office of Adjudication, 1400 Independence Avenue, S.W., Washington, D.C. 20250-9410, by fax (202) 690-7442 or email at*** ***program.intake@usda.gov*****.** RD/LIHTC

“This Institution is an equal opportunity provider and employer”

**** **EQUAL HOUSING OPPORTUNITY**