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**PRESCRIPTION DRUG EXPENSES VERIFICATION**

Date\_\_\_\_\_\_\_\_\_\_\_\_

To\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PHARMACY OR OTHER PRESCRIPTION DRUG PROVIDER

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

PHARMACY’S ADDRESS & TELEPHONE #

FROM\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

SITE MANAGER’S NAME

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

SITE MANAGER’S ADDRESS

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

HOUSEHOLD MEMBER’S NAME\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ADDRESS\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DATE OF BIRTH\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_SOCIAL SECURITY #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

The household member named above has applied for or is receiving federal rental assistance at our site. HUD requires that we verify information that is used in determining the household member’s eligibility and rent.

We would appreciate your cooperation in answering the question on this form and returning it to the site manager listed above. Enclosed is a self addressed, stamped envelope for this purpose. The household member has consented to the release of the information, as shown on the bottom of this page.

**INSTRUCTIONS**

The household member who signed this form indicated that he/she purchased drugs at your pharmacy.

To properly determine the household member’s rent and eligibility, please inform us if the household member is enrolled in the Medicare Discount Card & Transitional Assistance Program. (Individuals enrolled in this program will have a Medicare-approved discount drug card and/or a $600 transitional credit that can be used for their drug purchases.) If the household member is enrolled in this program, please provide the price of the prescription drugs before Medicare negotiated price benefit(this is the pre-discount price of the drugs) purchased by the household member in the previous year with the Medicare approved discount card and/or the $600 transitional assistance. Also provide the out-of-pocket cost to the household member for non-Medicare-discounted prescription drugs.

For those members who aren’t enrolled in the Medicare Discount Card and/or Transitional Assistance program, provide the out-of-pocket cost to the household member for the prescription drugs purchased at your pharmacy in the previous year.

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**INFORMATION REQUESTED**

Is household member currently enrolled in the Medicare Discount Card and/or Transitional program?

\_\_\_\_\_\_ **Yes.** Total annual costs for prescription medicines BEFORE Medicare negotiated price benefit PLUS out-of-pocket non-Medicare-discounted costs $\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_**No.** Total annual out-of-pocket costs for prescription medicines $\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

NAME & TITLE OF PERSON SUPPLYING INFORMATION DATE

**HOUSEHOLD MEMBER RELEASE**

**TO THE HOUSEHOLD MEMBER:** YOU DO NOT HAVE TO SIGN THIS FORM IF THE NAME OR ADDRESS OF EITHER THE SITE MANAGER OR THE PRESCRIPTION DRUG PROVIDER 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\_\_\_\_\_\_\_\_\_\_\_\_\_

**PENALTIES FOR MISUSING THIS VERIFICATION 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 42 U.S.C. 208 (f)(g) and (h). Violation of these provisions are cited as

violations of 42 U.S.C. 408f, g and h.

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

 **EQUAL HOUSING OPPORTUNITY**

