Medical Expenses Verification

To: ________________________________ Return to: ________________________________
________________________________ ________________________________
________________________________ ________________________________
Phone: ________________________________ Phone: ________________________________
Fax: ________________________________ Fax: ________________________________

I have applied or I am currently a resident at the above noted Apartment Community. It is of benefit to me to disclose and verify my medical expenses and all other reasonable, anticipated medical expenses for the next twelve months.

I understand I have signed a HIPPA release in your office and if I have failed to disclose my apartment community as an authorized recipient of the requested information, then I give you that permission at this time and would appreciate your cooperation in providing any medical expense information to the above noted address.

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Signature

________________________________ ________________________________ ____________________
Printed Name Social Security Number Date of Birth

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In determining your totals, do not use any expenses that are paid for by an outside source
(e.g.: insurance, Medicare or grants by a state agency or charitable organization.)

1. Medical Expenses for the previous 12 months: $__________________
2. Medical Expenses estimated for the next upcoming 12 months: $__________________

Note: In above totals include any one-time medical expenses.

Signature: ________________________________ Title: ________________________________

Printed Name: ________________________________ Date: ________________________________

Phone #: ________________________________ Fax #: ________________________________

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Note: If this is a HUD Financed property Individual Consent Authorization (FAM form #H004B) must be attached.