



# Norman Housing Authority

700 N. Berry Road

Norman, Oklahoma 73069

Phone (405) 329-0933

Fax (405) 573-0345

## PUBLIC HOUSING - MEDICAL EXPENSES VERIFICATION

Re:

Applicant/Participant Name

Social Security Number

D.O.B

Applicant/Participant Address

City

State

Zip

### ATTENTION MEDICAL PROVIDER

The person named above has either applied for or is receiving housing assistance. Since the rental rates on public housing units can be reduced for some families with medical expenses, we are required by law to obtain certain information with regard to these medical expenses. To comply with this requirement, we ask your cooperation by verifying *anticipated* medical expenses **not covered by a medical insurance plan** for the next twelve (12) months below regarding the referenced individual. We will use any information you provide only to determine the family's eligibility and rent.

We would greatly appreciate your prompt return of this form. If you have any questions or concerns, please call (405) 329-0933 ext. 309.

***Cristina Fuentes***

Norman Housing Authority Representative

### APPLICANT/PARTICIPANT RELEASE OF INFORMATION

I hereby consent to and authorize the release of information requested by Norman Housing Authority regarding my medical care expenses.

Signature of Applicant/Participant

Date

### TO BE COMPLETED BY MEDICAL PROVIDER FOR INDIVIDUAL REFERENCED ABOVE

Is the Individual's Condition likely to continue for the coming 12 months?  YES  NO

Based upon the individual's past medical history, in the coming 12 months, will the individual need to purchase Over-The Counter Medical Items?  YES  NO

If yes, please list items: \_\_\_\_\_

Please indicate the type of service you provide to the applicant/participant (check all appropriate):

Physician Care  Dental Care  Hospital/Clinic Care  Medical Office visits/Co-pays  Therapy

Other, please specify: \_\_\_\_\_

Based upon the individual's past medical history, the individual may anticipate the following costs for services checked above in the coming twelve (12) months: \$\_\_\_\_\_ (please do not count services paid by insurance)

**I certify that the above information is true and correct.**

Name of Person Completing Form

Title

Signature

Date

Address

Telephone Number

Please Return Form To:

Norman Housing Authority

Public Housing Office

Fax: (405) 573-0345

700 N. Berry Rd. Norman, OK, 73069