CAMBRIDGE HOUSING AUTHORITY

675 Massachusetts Avenue
Cambridge, MA 02139
www.cambridge-housing.org
TDD 800 545 1833 x112

MEDICAL EXPENSES VERIFICATION – LEASED HOUSING

Date of 1st Request: _____

TO: _____
Name of Medical Provider

Date of 2nd Request: _____

_____ _____ _____ _____ _____
Address City, State Zip Code Telephone Number Fax Number

RE: _____ _____
Applicant/Participant Name SSN

_____
Applicant/Participant Address City, State Zip Code

Dear Sir/Madam;

We are required to verify the incomes, expenses and other information of applicants/participants for eligibility and continued occupancy in the Public Housing Program/Leased Housing Program. We ask your cooperation by supplying the information requested below about the referenced person. We will use any information you provide only to determine the family's eligibility and rent, and pledge to keep the data in strict confidence.

We would greatly appreciate your prompt return of this form. Note that the person referenced has authorized your release of the information. If you have any questions, please feel free to contact our office. Thank you for your cooperation.

_____ _____ _____
CHA Employee Name Telephone Number Fax Number

APPLICANT/PARTICIPANT RELEASE OF INFORMATION

I hereby authorize the above captioned verifier to release the information requested below.

Name: _____ Signature: _____ Date: _____

TO BE COMPLETED BY MEDICAL PROVIDER/PHARMACIST

1. Is this individual's condition likely to continue for the coming 12 months? ☐ Yes ☐ No

2. Please indicate the type of service you provide to the applicant/participant:

☐ Physician Care	☐ Dental Care	☐ Hospital/Clinic Care
☐ Prescriptions	☐ Medical Office visits/Co-pays	
☐ Medical Transportation	☐ Over the Counter Prescriptions	☐ Other, please specify: _____

3. Projected cost of services during the next 12 months: $_____

4. Projected prescription expenses during the next 12 months:

	Cost per Refill	Frequency of Refill	Paid by Insurance?	
a.	_____	_____	☐ Yes	☐ No
b.	_____	_____	☐ Yes	☐ No
c.	_____	_____	☐ Yes	☐ No
d.	_____	_____	☐ Yes	☐ No
e.	_____	_____	☐ Yes	☐ No
f.	_____	_____	☐ Yes	☐ No

*If you need additional space, please use another blank page or attach a patient history print out from your pharmacy.

I certify that the above information is true and correct.

_____ _____
Name of Person Completing Form Title

_____ _____
Signature Date

_____ _____
Name of Company Telephone Number

_____
Address City, State Zip Code

WARNING: Section 1001 of Title 18 of the U.S. Code makes it a criminal offense to make willful false statements or misrepresentations to any Department or Agency of the United States as to any matter within its jurisdiction.