VERIFICATION OF MEDICAL EXPENSES

We are required by USDA Rural Development, an agency of the UNITED STATES DEPARTMENT OF AGRICULTURE, to verify all allowable medical expenses of elderly, handicapped or disabled household members, in excess of 3% of annual income. We ask your cooperation in supplying this information in the space below. All information submitted will be held in confidence for use only in determining the family's eligibility and rent.

Sincerely, _____, Project Manager

_____ _____
(Project Name) (Project Address)

_____ _____
(Date) (Telephone Number)

xxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxx

MEDICAL DATA

I hereby authorize the _____
(Source of Information)
to release all information requested below concerning my MEDICAL EXPENSES.

_____ X_____
(Applicant's Name) (Signature)

_____ _____
(Telephone Number) (Applicant's Address)

DOCTOR: Amount PAID past 12 months by PATIENT---------- $_____

HOSPITAL: Amount PAID past 12 months by PATIENT ---------- $_____

PHARMACY: Amount PAID past 12 months by PATIENT ----------$_____

OTHER: _____ $_____

REMARKS: _____

_____ _____
(Date) (Provider)

xxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxx

"This institution is an equal opportunity provider."

EQUAL HOUSING OPPORTUNITY