NORMAN HOUSING AUTHORITY

700 N. Berry Road, Norman, OK 73069
Phone 405-329-0933 Fax 405-329-2542

"Affordable Housing...with Vision"

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.

_____
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

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 one of the following:

Norman Housing Authority
Public Housing Office
700 N. Berry Road
Norman, OK 73069

Attn: Leasing Coordinator
Fax: (405) 857-6143
Email: kcothran@normanha.org