



Housing Assistance
2015 Felton Avenue
PO Box 4928
Macon, GA 31208

VERIFICATION OF ANTICIPATED MEDICAL EXPENSES

Section 8
 Public Housing

Date: _____ Name of Caseworker or RSC: _____

Applicant/Tenant's Name: _____

Address: _____
City State Zip

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

Signature of Applicant/Tenant

Date

The person named above has either applied for or is receiving housing assistance. Federal law requires that we verify anticipated medical expenses **NOT COVERED BY A MEDICAL INSURANCE PLAN** for the next twelve (12) months for applicants/tenants in our low-income housing programs. We ask that you please cooperate in supplying the information requested as promptly as possible. Thank you for your assistance.

Sincerely,

**Please return form to: Admissions Office
Macon Housing Authority
PO Box 4928
Macon GA 31208**

Housing Authority Representative

This is to certify that _____ anticipates medical expenses for the next

12 months of \$ _____ for: Medical Treatments Office Calls Clinic Visits Other

If 'Other', please explain: _____

Physician's Name (Please Print or Type): _____

Physician's Signature: _____ **Phone:** _____

Address: _____ **Date:** _____
Street City State Zip

WARNING! Title 18, Section 1001 of the United States Code, states that a person is guilty of a felony for knowingly and willingly making false or fraudulent statements to any department or agency of the United States government.