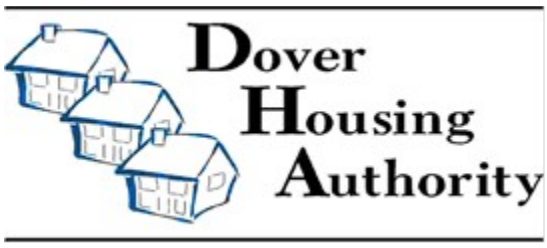

76 Stevenson Drive
Dover, DE 19901
302-678-1965 *voice*
302-678-1971 *fax*
1-800-545-1833, ext. 816 TDD
dover.housingauthority@dhade.org *email*

STATEMENT OF MEDICAL EXPENSES

TO: _____ Date _____

Dear Doctor:

The Department of Housing and Urban Development requires third party verification of all information submitted by anyone applying for or participating in a federally assisted program. The person named below has signed and agreed to the release of the requested information. This information will be kept in strict confidence.

Please complete the portion which is applicable to the applicant and return this form to our office as soon as possible.

Sincerely,

Occupancy Department

Name:

Address:

I hereby authorize the release of the information to the Dover Housing Authority for the purposes of determining my eligibility.

Date Signature

Name of Patient:

Does patient have a co-pay? Patient Liability $

Average cost per visit: $

Number of visits expected in next 13 months:

Estimated average cost per visit: $

This patient is covered by medical insurance or compensation:

If yes, give name, type