Macon Housing Authority
MAKING HOUSING AFFORDABLE

Section 8 Office
2015 Felton Avenue
Macon, GA 31201
Tel: 478-752-5000

VERIFICATION OF ANTICIPATED MEDICAL EXPENSES

Date:_____ **Name of Caseworker:** _____

Applicant/Tenant's Name: _____

Address:_____
City State Zip

I hereby consent to and authorize the release of information requested by Macon-Bibb County 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,

_____
Housing Authority Representative

Please return form to:
Section 8 Office
Macon-Bibb County Housing Authority
PO Box 4928
Macon GA 31208

This is to certify that _____ anticipates medical expenses for the next
Patient's Name
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.