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

# VERIFICATION OF ANTICIPATED PRESCRIPTION DRUG EXPENSES

☐ **Section 8**
☐ **Public Housing**

**Date:**_____ **Name of Caseworker or RSC:** _____

**Applicant/Tenant's Name**: _____

**Address:**_____
City State Zip

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I hereby consent to and authorize the release of information requested by Macon Housing Authority regarding my anticipated prescription drug expenses for the next 12 months.

_____ _____
**Signature of Applicant/Tenant** **Date**

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The person named above has either applied for or is receiving housing assistance. Federal law requires that we verify anticipated prescription drug 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:** **Admissions Office**
**Macon Housing Authority**
**PO Box 4928**
**Macon GA 31208**

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This is to certify that _____ anticipates prescription drug expenses
Patient's Name
for the next 12 months to be $_____.

**Pharmacy Name (**Please Print or Type)**:**_____

**Pharmacist's Signature:** _____**Phone:**_____

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

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**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.