Housing Authority of the City of Austin

1124 South IH 35, Austin, TX 78704
(512) 477-1314 Fax (512) 494-0686

HOUSING CHOICE VOUCHER PROGRAM
MEDICAL EXPENSES/ DISABILITY ASSISTANCE VERIFICATION

To:			From:	
Attn:			Date:	
Address:			Fax:	

ANNUAL ( ) INTERIM ( ) INITIAL ( )

HACA is required to verify the incomes, assets, and expenses of all members of families applying for or living in federally assisted housing. To comply with these requirements, HACA asks for your cooperation in supplying the information requested below. HACA will keep such information confidential and use it only to determine this applicant's eligibility and rent. Your prompt return of this form by mail or fax is greatly appreciated.

NOTE: HUD requires that the applicant must not assist in any way with the process of obtaining income verification. Section 1001 of Title 18 of the U.S. Code makes it a criminal offense to make willful false statements or misrepresentation to any Department or Agency of the United States as to matters within its jurisdiction.

Name ______________________ S. S. N: ______________________

Date of Birth: ______________________

Address: ______________________ Client No: ______________________

I hereby authorize the release of the information requested below to the Housing Authority of the City of Austin.

______________________ ______________________
Signature Date

1. Type of service you provide to family (Check all appropriate):
   - ☐ Physician Care ☐ Prescriptions ☐ Dental Care ☐ Hospital/Clinic Care
   - ☐ Medical Transportation ☐ Therapy ☐ Attendant care ☐ Other: ____________
2. Applicable insurance ☐ Medicare ☐ Medicaid ☐ Other: ____________ ☐ No Insurance
3. Non-reimbursable costs of services: $____________ per ☐ week ☐ month
4. How long will the service(s) be necessary over the next 12 months? ______ weeks ______ months
5. If the person above purchases prescriptions from you, please answer the following:

Prescription	Cost	Monthly	Bi-monthly
	$		
	$		
	$		

(ATTACH ANY ADDITIONAL PRESCRIPTION INFORMATION ON SEPARATE SHEET OF PAPER)

6. Comments: ____

Representative: ______________________ Phone No: ______________________

Signature: ______________________ Date: ______________________

Title: ______________________