VERIFICATION OF MEDICAL EXPENSES

REQUEST FOR INFORMATION

Federal regulations require us to verify financial information provided by applicants for housing assistance. We ask your cooperation in supplying the information requested. The attached Form 3550-1, Borrower's Certification and Authorization provides the applicant's authorization.

Your prompt return of the requested information will be appreciated. A self-addressed return envelope is enclosed for your convenience. If you have questions, please call _____ at _____.

APPLICANT IDENTIFICATION

Name _____ Social Security Number_____

REQUESTED INFORMATION

1. Please list the purpose of any accumulated medical bills, identify to whom the amount is owed, and provide the amount to be paid during the coming 12 months.

Amount	**Owed To**	**Medical Expenses for**

2. Medical Insurance Premiums

   $_____ Amount Paid Payment Period: __ per month, ___ per year

   Medical Insurance Premiums

   $_____ Amount Paid Payment period: __ per month, ___ per year

3. List other anticipated medical expenses

VERIFIER INFORMATION: Please sign this verification form and print the name, address and telephone number of the verifier.

Name:_____ Title:_____

_____ Telephone Number:_____
(Signature)

WARNING: Knowingly and willingly making a false or fraudulent statement to any department of the United States Government is a felony punishable by fine and imprisonment (Title 18, Section 1001, U.S. Code)

(12-23-96) SPECIAL PN