



**"POINTING TOWARDS PROGRESS"**

**Pontiac Housing Commission**

CLARENCE PHILLIPS, Mayor  
JANICE TIPTON, President  
HAROLD HOLLAND, Vice-President  
YOLANDA GOMEZ STUPKA, Commissioner  
ALMA V. SHELTON, Commissioner  
MALKIA MAISHA, Commissioner  
FRANKLIN HATCHETT, Executive Director

*132 Franklin Boulevard  
Pontiac, Michigan 48341  
(248) 338-4551  
Fax (248) 338-7996*

DATE:

RE: **MEDICAL EXPENSES**

APPLICATN/TENANT:

ADDRESS:

CITY/ST/ZIP:

SOCIAL SECURITY NUMBER:

TO WHOM IT MAY CONCERN:

FEDERAL REGULATIONS REQUIRE THAT WE VERIFY INCOME, ASSETS, AND EXPENSES OF APPLICANTS AND/OR PARTICIPANTS FOR FEDERAL HOUSING ASSISTANCE.

IN ORDER THAT WE MAY CARRY OUT OUR RESPONSIBILITIES TO THE PUBLIC IN A FAIR AND IMPARTIAL MANNER, CERTAIN ESSENTIAL ITEMS OF INFORMATION ARE NECESSARY. ONE OF THESE ITEMS IS THE CURRENT VERIFICATION OF MEDICAL EXPENSES PAID BY THE APPLICANTS/OR PARTICIPANTS.

THE APPLICANT/TENANT IDENTIFIED ABOVE MAY/DOES PAY MEDICAL EXPENSES TO YOU.

PLEASE FILL IN THE FORM ON THE REVERSE SIDE AND RETURN IT TO US AS SOON AS POSSIBLE. THE INFORMATION WILL BE USED TO DETERMINE THEIR ELIGIBILITY STATUS AND RENT FOR THE CLAIMANT'S FAMILY.

SINCERELY,

PONTIAC HOUSING COMMISSION  
LEASING AND OCCUPANCY

## MEDICAL EXPENSE VERIFICATION

THIS IS TO CERTIFY THAT \_\_\_\_\_ ANTICIPATION

MEDICAL EXPENSES IN THE COMING 12 MONTHS FOR \_\_\_\_\_

\_\_\_\_\_ (TYPE OF EXPENSE SUCH AS MEDICAL TREATMENT, ETC),

WHICH IS NOT COVERED BY INSURANCE IN THE AMOUNT OF \$ \_\_\_\_\_

\_\_\_\_\_  
SIGNATURE OF AUTHORIZED PERSONAL

\_\_\_\_\_  
TITLE OF AUTHORIZED PERSONAL

\_\_\_\_\_  
DOCTORS NAME (PRINT OR TYPE)

\_\_\_\_\_  
SIGNATURE OF DOCTOR

\_\_\_\_\_  
ADDRESS

\_\_\_\_\_  
CITY/STATE/ZIP

\_\_\_\_\_  
TELEPHONE NUMBER

\_\_\_\_\_  
DATE