VERIFICATION OF MEDICAL PAYMENT PLAN

Date:_____ Name of Applicant/Tenant:_____
Address of Applicant/Tenant:_____
To: _____

_____

VERIFICATIONS REQUEST

The household named above has applied, or is recertifying eligibility, for federal housing assistance at WillowCreek Manor. HUD requires us to verify all information used to determine the household's eligibility or level of benefits. We would appreciate you taking the time to provide the information requested below. The household member has consented to the release of this information by signing below. Please return the completed form by fax to: 316-683-6407. If you have any questions, please call me at (316) 683-5224.

Sincerely,

Manager
WillowCreek Manor, 1301 S. Bleckley, Wichita, KS 67218

RELEASE

By my signature below, I hereby consent to the release of the information requested.

Signature of Applicant/Tenant _____ Date_____

MEDICAL PAYMENT PLAN VERIFICATION:

The above-named household member states that he/she has a payment plan with you for medical services rendered. We would like to verify that plan:

Total amount of bill (actual or anticipated): $_____

Amount of monthly payment to be paid: $_____

Are monthly payments being made as agreed: ☐ Yes ☐ No

Remarks: _____

_____

_____

Name & Title of Person Supplying Information _____
Phone_____

Signature_____ Date_____

Title 18, Section 1001 of the U.S. Code states that a person is guilty of a felony for knowingly and willingly making false or fraudulent statements to any department of the United States Government. HUD, the PHA and any owner may be subject to penalties for unauthorized disclosure or improper uses of information collected based on the consent form. Use of the information collected is restricted strictly to the purposes cited above.