

## VERIFICATION OF ITEMIZED LIST OF OVER-THE COUNTER MEDICATIONS

Date: \_\_\_\_\_

Property Name: \_\_\_\_\_  
Telephone: \_\_\_\_\_  
Fax: \_\_\_\_\_

Property Address: \_\_\_\_\_  
Address 2: \_\_\_\_\_  
TTD/TTY: \_\_\_\_\_

TO:

Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
City, State, Zip: \_\_\_\_\_

Re: Resident/ Applicant

Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
City, State, Zip: \_\_\_\_\_  
SSN: \_\_\_\_\_  
Unit: \_\_\_\_\_

(Please return this form to the above address)

### HOUSEHOLD MEMBER RELEASE

TO THE HOUSEHOLD MEMBER:

YOU DO NOT HAVE TO SIGN THIS FORM IF THE NAME OR ADDRESS OF EITHER THE PROJECT OR ADULT AND FAMILY SERVICES OFFICE IS LEFT BLANK.

RELEASE: I hereby authorize the release of the requested information. Information obtained under this consent is limited to information that is no older than 12 months. There are circumstances which would require the owner to verify information that is up to 5 years old, which would be authorized by me on a separate consent attached to a copy of this consent.

Signature \_\_\_\_\_ Date \_\_\_\_\_

We are required to verify out-of-pocket medical expenses to determine the amount of housing assistance provided to the household. We ask your cooperation in supplying the requested information listed below.

Signed \_\_\_\_\_ (Property Representative)

### PLEASE COMPLETE THE FOLLOWING:

In accordance with HUD Handbook 4350.3 Revision 1, Change 2, out of pocket medical expenses can be used to reduce the annual income for the household. Please indicate if the over the counter purchases indicated are recommended by you to address a specific medical condition.



## VERIFICATION OF ITEMIZED LIST OF OVER-THE COUNTER MEDICATIONS

RECEIPTS ARE REQUIRED FOR NON-PRESCRIPTION ITEMS

Name of Non-Prescription Item	<u>Recommended</u> – Yes or No	<u>Dosage</u>	<u>Daily</u> <u>Weekly</u> <u>Monthly</u>	<u>To Treat a</u> <u>Specific</u> <u>Medical</u> <u>Condition or for</u> <u>General Good</u> <u>Health</u>
1.	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> D <input type="checkbox"/> W <input type="checkbox"/> M	<input type="checkbox"/> Treat Cond <input type="checkbox"/> Good Health
2.	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> D <input type="checkbox"/> W <input type="checkbox"/> M	<input type="checkbox"/> Treat Cond <input type="checkbox"/> Good Health
3.	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> D <input type="checkbox"/> W <input type="checkbox"/> M	<input type="checkbox"/> Treat Cond <input type="checkbox"/> Good Health
4.	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> D <input type="checkbox"/> W <input type="checkbox"/> M	<input type="checkbox"/> Treat Cond <input type="checkbox"/> Good Health
5.	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> D <input type="checkbox"/> W <input type="checkbox"/> M	<input type="checkbox"/> Treat Cond <input type="checkbox"/> Good Health
6.	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> D <input type="checkbox"/> W <input type="checkbox"/> M	<input type="checkbox"/> Treat Cond <input type="checkbox"/> Good Health
7.	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> D <input type="checkbox"/> W <input type="checkbox"/> M	<input type="checkbox"/> Treat Cond <input type="checkbox"/> Good Health
8.	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> D <input type="checkbox"/> W <input type="checkbox"/> M	<input type="checkbox"/> Treat Cond <input type="checkbox"/> Good Health

## VERIFICATION OF ITEMIZED LIST OF OVER-THE COUNTER MEDICATIONS

Name of Non-Prescription Item	<u>Recommended</u> – Yes or No	<u>Dosage</u>	<u>Daily</u> <u>Weekly</u> <u>Monthly</u>	<u>To Treat a</u> <u>Specific</u> <u>Medical</u> <u>Condition or for</u> <u>General Good</u> <u>Health</u>
9.	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> D <input type="checkbox"/> W <input type="checkbox"/> M	<input type="checkbox"/> Treat Cond <input type="checkbox"/> Good Health
10.	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> D <input type="checkbox"/> W <input type="checkbox"/> M	<input type="checkbox"/> Treat Cond <input type="checkbox"/> Good Health
11.	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> D <input type="checkbox"/> W <input type="checkbox"/> M	<input type="checkbox"/> Treat Cond <input type="checkbox"/> Good Health
12.	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> D <input type="checkbox"/> W <input type="checkbox"/> M	<input type="checkbox"/> Treat Cond <input type="checkbox"/> Good Health
13.	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> D <input type="checkbox"/> W <input type="checkbox"/> M	<input type="checkbox"/> Treat Cond <input type="checkbox"/> Good Health
14.	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> D <input type="checkbox"/> W <input type="checkbox"/> M	<input type="checkbox"/> Treat Cond <input type="checkbox"/> Good Health
15.	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> D <input type="checkbox"/> W <input type="checkbox"/> M	<input type="checkbox"/> Treat Cond <input type="checkbox"/> Good Health
16.	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> D <input type="checkbox"/> W <input type="checkbox"/> M	<input type="checkbox"/> Treat Cond <input type="checkbox"/> Good Health
17.	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> D <input type="checkbox"/> W <input type="checkbox"/> M	<input type="checkbox"/> Treat Cond <input type="checkbox"/> Good Health

## VERIFICATION OF ITEMIZED LIST OF OVER-THE COUNTER MEDICATIONS

### PENALTIES FOR MISUSING THIS FORM

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 (or any employee of HUD, the PHA or the owner) may be subject to penalties for unauthorized disclosures or improper uses of information collected based on the consent form. Use of the information collected based on this verification form is restricted to the purposes cited above. Any person who knowingly or willfully requests, obtains or discloses any information under false pretenses concerning an applicant or participant may be subject to a misdemeanor and fined not more than \$5,000. Any applicant or participant affected by negligent disclosure of information may bring civil action for damages, and seek other relief, as may be appropriate, against the officer or employee of HUD, the PHA or the owner responsible for the unauthorized disclosure or improper use. Penalty provisions for misusing the social security number are contained in the Social Security Act at 208 (a) (6), (7) and (8). Violation of these provisions are cited as violations of 42 U.S.C. 408 (a) (6), (7) and (8).

**I understand the provisions provided in Title 18 above. I certify that I am currently licensed to prescribe medicine in the state of [Minnesota](#) and that the information provided on this form is true and correct.**

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Name and Title Health Care Provider

\_\_\_\_\_  
Company

\_\_\_\_\_  
Address/City/State/Zip

\_\_\_\_\_  
Telephone Number

\_\_\_\_\_  
Date

