

**LOUDOUN COUNTY DEPARTMENT OF FAMILY SERVICES  
HOUSING CHOICE VOUCHER DIVISION  
102 HERITAGE WAY, NE, SUITE 103  
LEESBURG, VA 20176  
703-777-0353  
703-737-8895 FAX**



**VERIFICATION OF MEDICAL INSURANCE PREMIUMS**

This will authorize \_\_\_\_\_ (name of agency) to release the information requested below regarding my medical insurance.

\_\_\_\_\_  
Full Name (Please Print or Type)

\_\_\_\_\_  
Social Security Number

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Street Address

\_\_\_\_\_  
Date

\_\_\_\_\_  
City                      State                      Zip

**TO WHOM IT MAY CONCERN:**

The individual named above is a resident/applicant for housing which has rents that are subsidized through the U.S. Department of Housing and Urban Development's Housing Choice Voucher Assistance Payment Program. Federal regulations require that in order for a family to be eligible for this form of assistance, the income of the family, expenses, and other information related to eligibility must be verified. The information requested below will be held in strict confidence as is required under the provisions of the Virginia Privacy Protection Act, and will be used only to determine the eligibility of the family for the housing subsidy. Thank you for your cooperation in completing those applicable portions of this inquiry and returning it in the enclosed, self-addressed envelope.

\_\_\_\_\_  
Meg Asaro, Housing Counselor  
Ursula Brinkley, Housing Counselor  
Christine Hillock, Housing Counselor  
Tandi Hoffmann, Housing Counselor  
Yasmina Turner, Bilingual Housing Counselor  
Cyndy Wyrick, Housing Counselor  
Antwaun Jackson, HCV Division Manager

\_\_\_\_\_  
Date

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Policy Number (to be filled in by applicant):  
\_\_\_\_\_

Amount paid for insurance:  
\$ \_\_\_\_\_

Monthly      Yearly      Other: \_\_\_\_\_  
(circle one)

Amount of deductibles:  
\$ \_\_\_\_\_

Total amount of hospital bills not covered by insurance:  
\$ \_\_\_\_\_

Monthly amount family has agreed to pay or will pay calculated on a twelve month basis:  
\$ \_\_\_\_\_

\_\_\_\_\_  
Print Name

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

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Title

**WARNING: Section 1001 of Title 18 of the U.S. Code makes it a criminal offense to make willful false statements or misrepresentations to any Department or Agency of the United States as to any matter within its jurisdiction.**