HOUSING AUTHORITY OF BERGEN COUNTY
ONE BERGEN COUNTY PLAZA, 2ND FLOOR
HACKENSACK, N.J. 07601
PHONE: 201-336-7600
FAX: 201-336-7630
WWW.HABCNJ.ORG

IMPORTANT INFORMATION
PLEASE READ CAREFULLY

The following guide will help you to gather all of your anticipated out of pocket paid medical expenses for your annual recertification.

Please note that all of the information must be current and within 60 days of your recertification interview.

All information must be photocopied and ready to be handed to your caseworker at the interview. To avoid delays for the next appointment copies cannot be made.

Type of Expense	Copies of Documents Required
Prescribed Medication	1. Provide a note from your doctor listing all the medication you are anticipated to take in the next 12 month. Please have the doctor give both the brand and the generic name of the medication. 2. Provide your prescription print out for the last 12 months including your cost per medication.
Doctor/Hospital Visits	Provide a letter from your doctor/medical facility stating how many times in the coming year they anticipate you will need to see them and your out of pocket cost per visit.
Health Insurance Premium – Medical Alarm	Provide the most current billing statement indicating the monthly or annual cost of your premium.

SAMPLE LETTER

Date

To: Housing Authority of Bergen County
Re: Patient's Name

Please be advised that (Patient's Name) is a patient under my care. He/She is required to take the following medication for the next 12 months:

List medication:

I anticipate that (Patient's Name) will be seen in my office for medical care/routine care XX times per year. Each visit costs the patient $XX.XX out of pocket.

Sincerely,
Doctor's Name
Title

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Date:_____

To: **Housing Authority of Bergen County**

Please be advised that _____ is a patient under my care. He/She is required to take the following medication for the next 12 months:

List medication:

I anticipate that _____ will be seen in my office for medical care/routine care _____times per year. Each visit costs the patient $_____ out of pocket.

I, _____ [name of health care provider or other appropriate documenting authority], certify that I am a professional competent to render the opinion and knowledgeable about the person's situation. Furthermore I certify that the information listed above is accurate and complete.

_____
Name of health care provider or other documenting authority

_____
Signature

_____
Date

Address: _____
_____
_____