NOTICE OF INTENT TO MAKE A CLAIM

Contact Information

Name: _____

Current Address: _____
Street Address Unit Number

_____
City State Zip Code

Current Phone Number(s): Cell: _____ Home: _____

Work: _____

Email address: _____

HANO Residency

Describe when and where you lived within public housing facilities owned by the Housing Authority of New Orleans ("HANO") from 1998 to August 29, 2005. For each apartment in which you lived, provide the name of the person leasing the unit from HANO.

Unit	Dates of Occupancy	Address	Person Leasing Unit
1			
2			
3			
4			

Please submit additional pages if you lived in more than 4 units.

Nature of your Claim(s)

For each unit listed above, identify the units in which you claim mold to have been present and the periods in which you maintain mold was present in the unit.

Unit	Was Mold Present Yes or No	Dates on Which Mold Was Present
1		
2		
3		
4		

For each unit listed above in which mold was present, describe where mold was in your unit as well as its general extent:

1.

2.

3.

4.

For each unit listed above in which mold was present, describe the cause of the mold presence in the unit, if known:

1.

2.

3.

4.

For each unit listed above, describe any documentary evidence you have of the existence of mold, including, for example, pictures or maintenance records.

1.

2.

3.

4.

You may attach copies of any records or evidence you have.

For each unit listed above in which mold was present, provide the names and contact information of any witnesses (other than yourself) who you believe may be able to testify as to the presence of mold:

1.

2.

3.

4.

For each unit listed above, describe the nature and extent of damages you claim to have experienced, including property damage you experienced:

1.

2.

3.

4.

As to the damages you claim to have experienced while living in each unit listed above, describe any documentary evidence you have substantiating those damages, including, for example, receipts for replaced property.

1.

2.

3.

4.

You may attach copies of any records or evidence you have.

For each unit listed above in which mold was present, provide the names and contact information of any witnesses (other than yourself) who you believe may be able to testify as to the existence of your damages:

1.

2.

3.

4.

CLAIMANT MEDICARE FORM FOR RESIDENTS/FORMER RESIDENTS SUBMITTING CLAIMS ON THEIR OWN BEHALF

Claimant Information

Full Legal Name: _____

Date of Birth (MM/DD/YYYY): _____

Address: _____

Phone / Email: _____

Claimant Status (Personal Claim as Resident/Former Resident)

Are you submitting this claim on behalf of yourself, as a person who lived at either Guste Homes or B.W. Cooper during the applicable periods?

☐ Yes – **PLEASE COMPLETE THIS FORM**

☐ No – **YOU SHOULD NOT COMPLETE THIS FORM**

(Persons submitting claims not on their own behalf, but on behalf of family members who were residents of Guste Homes or B.W. Cooper, are NOT required to complete this form or give their Medicare status or information.)

Medicare Status (Required for Residents/Former Residents asserting Personal Claims)

Are you currently enrolled in Medicare?

☐ Yes

☐ No

☐ Not Sure

If Yes, please provide (if available):

Medicare Beneficiary Identifier (MBI): _____
OR

Last 5 digits of SSN: _____

This information is requested solely for compliance with federal reporting obligations.

Medical Treatment Representation

Check all that apply:

☐ I am not seeking compensation for medical expenses of any kind

☐ I have not submitted or relied upon medical bills or records in connection with this claim

☐ I have not seeking compensation for medical treatment related to the allegations in this case

☐ I am not seeking compensation for future medical care

Conditional Payment Representation

☐ To the best of my knowledge, Medicare has not made any payments for medical care related to the allegations in this claim

☐ I am not aware of any Medicare lien or reimbursement claim related to the allegations in this case

Acknowledgment and Cooperation

I agree to provide additional information reasonably requested for purposes of compliance with applicable obligations under the Medicare Secondary Payer Act and Section 111 of the Medicare, Medicaid, and SCHIP Extension Act of 2007. I understand that such information will be used solely for compliance purposes.

Certification

I declare that the information provided in this Claim Form is true and correct to the best of my knowledge.

Signature: _____
Date: _____