Disability Assistance Expense Allowance
Information Packet

ELIGIBILITY

- You may request a Disability Assistance Deduction if someone in your family is disabled, and assistance is required so that someone, either the disabled household member or another adult, can work.

ALLOWABLE DISABILITY ASSISTANCE EXPENSES

You may request a disability assistance expense deduction for anticipated disability assistance expenses for the coming year that will not be paid or reimbursed from another source if those expenses meet the criteria below.

- Expenses are for attendant care and / or equipment that allow a family member to work

Examples include attendant care, wheelchair, ramps, modifications to vehicles, or special equipment for visual or hearing impairments. Please note that there are limits on the amount of expenses you may deduct based on your income.

LISTING YOUR EXPENSES FOR THE COMING YEAR

To ensure full consideration of your disability assistance expenses, all expenses must be listed on the itemized statement within the attached form. You will be asked to list ongoing disability assistance expenses that will continue into the coming year, as well as any anticipated one-time disability expenses. Please attach receipts for ongoing expenses only. Please do not send receipts for "one-time" disability assistance expenses that will not continue past your re-examination date.

VERIFICATION

We must verify the information you provide about your expenses directly with your doctor, pharmacist, or other licensed health care provider. On the reverse side of the attached form, please include the name, medical group, address, and phone number of each health care provider included on your itemized list of expenses. If you feel that your doctor is not aware of your expenses, you may wish to discuss your situation with him or her before we send the request for verification.

If you need additional information, please call the Information Center at (831) 454-9455 ext. 601
(Si desea una traduccion de esta carta, por favor llame al (831) 454-9455 ext. 601)

Itemized Statement of Disability Assistance Expenses

Tenant Name: _____ Tenant ID: _____ Date: _____

THE HOUSING AUTHORITY WILL VERIFY ALL ANTICIPATED EXPENSES WITH YOUR DOCTOR, OR OTHER LISCENSED HEALTH CARE PROVIDER.

LIST ONGOING DISABILITY EXPENSES HERE

Name Of Disabled Family Member	Name Of Family Member Who Will Be Able To Work	Type of Disability Expense	Annual (yearly) amount	Name of Licensed Health Care Provider	Original Receipts Attached ?	Housing Authority Use Only!
Bob	*Jane*	*Attendant Care*	*$6,000*	*Judy Stevens*	*Yes*	

LIST ANTICIPATED ONE-TIME DISABILITY EXPENSES HERE

Name Of Disabled Family Member	Name Of Family Member Who Will Be Able To Work	Type of Disability Expense	Annual (yearly) amount	Name of Licensed Health Care Provider	Original Receipts Attached ?	Housing Authority Use Only!

I certify that the above information is true, correct and complete, and that these expenses are paid by me and not reimbursed by any other source (insurance, etc.):

Warning – Title 18 section 1001 of the United States Code states that any person would be guilty of a felony for knowingly and willingly making false or fraudulent statements to any Department or Agency of the United States.

Tenant Signature _____ Total Disability Assistance Expenses $_____

PLEASE COMPLETE THE REVERSE SIDE OF THIS FORM.

Contact Information of Licensed Health Care Providers

PLEASE USE THE SPACE BELOW TO PROVIDE THE NAME, MEDICAL GROUP, ADDRESS, AND PHONE NUMBER OF EACH LISCENSED HEALTH CARE PROVIDER ON YOUR ITEMIZED LIST OF DISABILITY ASSISTANCE EXPENSES.

1.

Name of Licensed Health Care Provider | *Medical Group*

Address | *Phone Number / Fax Number*

2.

Name of Licensed Health Care Provider | *Medical Group*

Address | *Phone Number / Fax Number*

3.

Name of Licensed Health Care Provider | *Medical Group*

Address | *Phone Number / Fax Number*

4.

Name of Licensed Health Care Provider | *Medical Group*

Address | *Phone Number / Fax Number*

5.

Name of Licensed Health Care Provider | *Medical Group*

Address | *Phone Number / Fax Number*

6.

Name of Licensed Health Care Provider | *Medical Group*

Address | *Phone Number / Fax Number*

7.

Name of Licensed Health Care Provider | *Medical Group*

Address | *Phone Number / Fax Number*

8.

Name of Licensed Health Care Provider | *Medical Group*

Address | *Phone Number / Fax Number*

9.

Name of Licensed Health Care Provider | *Medical Group*

Address | *Phone Number / Fax Number*