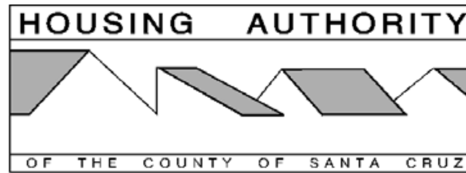

Medical Expense Allowance Information Packet

ELIGIBILITY

- You may request a Medical Expense Deduction if either the head of household or the spouse of the head of household is at least 62 years of age or disabled.

ALLOWABLE MEDICAL EXPENSES

You may request a medical expense deduction for anticipated medical 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 the diagnosis, cure, treatment, and prevention of a specific disease or illness
- Expenses are deemed medically necessary by a licensed health care practitioner
- Expenses are prescribed by a medical doctor

Medical expenses do not include expenses that are merely beneficial to general health, such as vitamins, gym memberships, or healthy foods that meet normal nutritional needs.

Examples of anticipated medical expenses include prescription drugs, eyeglasses, unpaid doctor and hospital bills that include a payment plan, insurance premiums, hearing aids, dental care, etc. 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 medical expenses, all expenses must be listed on the itemized statement within the attached form. You will be asked to list ongoing medical expenses that will continue into the coming year, as well as any anticipated one-time medical expenses. Examples of ongoing expenses include prescriptions, insurance premiums, physical therapy or attendant care, and payments on outstanding medical bills with a payment plan agreement. Please attach receipts for ongoing expenses only. Please do not send receipts for "one-time" medical 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, dentist, 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 Medical Expenses

Tenant Name: __________________________ Tenant ID: _________________ Date: __________

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

1. LIST MEDICATIONS YOU ARE PURCHASING

Name Of Family Member	Type of Medication	Frequency of Purchase	Family Cost per Purchase	Pharmacy Name	Original Receipts Attached ?	Housing Authority Use Only!

2. LIST UNPAID BALANCES AND PAYMENT PLAN AGREEMENTS

Name Of Family Member	Balance Due	Payment Plan	Physician's Office	Housing Authority Use Only!

3. LIST REGULARLY SCHEDULED HEALTH CARE APPOINTMENTS

Name Of Family Member	Patient Expense or Co-Pay	Frequency of Visits	Physician's Office	Housing Authority Use Only!

4. LIST OUT OF POCKET MEDICAL INSURANCE PREMIUMS

Name Of Family Member	Monthly Cost to Family	Insurance Provider	Housing Authority Use Only!

Itemized Statement of Medical Expenses, Continued

5. LIST OTHER ONGOING MEDICAL EXPENSES HERE					
Name Of Family Member	**Type of Medical Expense**	**Annual (yearly) amount**	**Name of Licensed Health Care Provider**	**Original Receipts Attached?**	Housing Authority Use Only!

6. LIST ANTICIPATED ONE-TIME MEDICAL EXPENSES HERE					
Name Of Family Member	**Type of Medical Expense**	**Annual (yearly) amount**	**Name of Licensed Health Care Provider**	**Cost Estimate / Proposal 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 Requested Medical Expenses $__________

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 MEDICAL 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*

050343 06/30/05 jp