

Medical Expense Allowance Information Packet

ELIGIBILITY

 You may request a <u>Medical Expense Deduction</u> if either the head of household or the spouse (or registered domestic partner) is at least 62 years of age, or has a long term / permanent disability. Temporary disabilities do not qualify participants for the Medical Expense Deduction.

ALLOWABLE MEDICAL EXPENSES

You may request a medical expense deduction for <u>anticipated</u> medical expenses for the coming year that will not be paid or reimbursed from another source if those expenses meet the definition below.

Definition of Allowable Medical Expense: Medical expenses are the costs of diagnosis, cure, mitigation, treatment, or prevention of disease, and the costs for treatments affecting any part or function of the body.

These expenses include payments for legal medical services rendered by physicians, surgeons, dentists, and other medical practitioners. They include the costs of equipment, supplies, and diagnostic devices needed for these purposes. Medical expenses must be primarily to alleviate or prevent a physical or mental defect or illness. They do not include expenses that are merely beneficial to general health, such as vitamins or a vacation. Medical expenses include the premiums you pay for insurance that covers the expenses of medical care, and the amounts you pay for transportation to get medical care. Medical expenses also include amounts paid for qualified long-term care insurance contract.

Examples of anticipated medical expenses include prescription drugs, eyeglasses, unpaid doctor and hospital bills that include a payment plan, insurance premiums, Medicare Part D premiums, hearing aids, dental care, transportation / mileage to health care appointments, 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 statements within the attached forms. On the attached forms, 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. If you cannot fit all of your expenses onto the required forms, please make additional copies as needed. Examples of ongoing expenses include prescriptions, insurance premiums, physical therapy or attendant care, and payments on outstanding medical bills with a payment plan agreement. To protect your confidentiality, do not submit receipts or statements with your expense forms.

VERIFICATION OF YOUR EXPENSES

The Housing Authority may contact the health care provider to verify the <u>cost</u> of the out of pocket expenses that you reported. Please understand that each verification form includes a self certification statement, and any false information you report may cause you to repay the Housing Authority for subsidy overpaid on your behalf, and / or may result in termination from the program.

HOW TO COMPLETE THE FORMS

- 1. First, review the attached forms. There are separate forms for different kinds of expenses. Therefore, there are forms for:
 - a. <u>Medications</u> Use this form for prescription and over the counter medications.
 - b. <u>Health Care Appointments and Payment Plans</u> Use this form for any regular, ongoing appointments or unpaid balances that you are paying off with a payment plan.
 - c. <u>Medical Insurance Premium</u>s Use this form for your insurance premiums. *For this form only, please include a copy of your bill, or other proof of payment.*
 - d. <u>Anticipated One Time Expenses</u> Use this form for one time expenses that you anticipate for the next twelve months. Many medical expenses cannot be anticipated. However, some expenses such as eyeglasses, hearing aides, and dental work can sometimes be anticipated.
 - e. Transportation / Mileage to health care appointments
- 2. When all of the forms are complete you must sign the bottom of the forms, certifying that all of the information is true, correct, and complete, and that you will not be reimbursed for the expenses.
- 3. Submit the completed forms to the Housing Authority. The Housing Authority will review each of your expenses to determine if they are allowable. Please understand that the Housing Authority cannot review your expenses or begin any deductions unless we receive all of the required documentation by the due date established in the cover letter. Therefore, it is in your best interest to submit completed and signed forms to the Housing Authority as soon as possible. If you do not submit all required documentation by the due date established in the cover letter, the Housing Authority will not be able to process your medical expenses with this year's annual re-examination. In such cases, you will not have any other opportunities to provide documentation of your medical expenses until your next annual re-examination next year.

HOW MEDICAL EXPENSES IMPACT YOUR PORTION OF RENT

The Housing Authority will review and evaluate each of the medical expenses that you list, to determine whether or not they meet the criteria above and have been sufficiently verified. Some or all of your expenses may be determined <u>not</u> to be allowable. Allowable costs will be added up, and the portion of your allowable expenses that exceeds three percent of your annual income will be deducted from your income for the purpose of determining your rent. Therefore, if your medical expenses are very small in proportion to your income, you may not receive any medical allowance at all. The final amount of the medical expense allowance will appear on the rent change notice that you receive.

If you need additional information, please call the Information Center at (831) 454-9455 ext.711 (Si desea una traduccion de esta carta, por favor llame al (831) 454-9455 ext. 711)



MEDICAL EXPENSE VERIFICATION FORM Out of Pocket / Unreimbursed Expenses for: MEDICATIONS

Head of Household:				Tenant ID:			
	Jse the form below to record information about each medication that you have an ongoing prescription for, which you will not be reimbursed for, and which you pay out of pocket.						
		_	pense: Medical expenses a and the costs for treatme		_	_	
other r these p illness vacation care, a	nedical practition ourposes. Medical They do not in on. Medical expend the amounts yor qualified long-t	ers. They include expenses include to ou pay for trar	legal medical services rendude the costs of equipment, ust be primarily to alleviates that are merely beneficion to get medical costs and limited amounts pair	supplies, and de or prevent a pal to general horsurance that co are. Medical ex	liagnostic devices physical or ment ealth, such as vi vers the expenses spenses also inclu	s needed for tal defect or tamins or a s of medical ade amounts	
Item	Name Of Family Member	Type of Medica	l Expense	# of Times Per Year	Family Cost per Purchase	Housing Authority Use	
1.		Prescription	Over the Counter				
I here that th knowl	by certify that the perfequency of purcedge.	erson named abo chase and <u>un-rei</u>	an allowable medication, as ove receives an allowable medinbursed family cost per purcha	cation on an ongo	_		
	me:						
с. Тур	e of health care provi	der:					
of the exa felony	spenses listed above.	Warning – Title	rrect, and complete, and that I hav 18 Section 1001 of the United St false or fraudulent statements t	tates Code states th	hat any person wou	ld be guilty of	
X Prin	t Name of Head of He	ousehold	Signature		Date		



MEDICAL EXPENSE VERIFICATION FORM

Out of Pocket / Unreimbursed Expenses for: HEALTH CARE APPOINTMENTS / PAYMENT PLANS

Head of Household: Tenant ID:						
unpaid Informa	balances with pution must be ve	record information about any ongoing, response to payment plan agreements, which you will rerified by a doctor or other health care pro I Expense Deduction.	not be reimburs	ed for, and which	ch you pay ou	t of pocket.
		able Medical Expense: Medical expention of disease, and the costs for				
other n these p illness. vacation care, and	nedical praction of they do not they do not the amount qualified los	ude payments for legal medical servitioners. They include the costs of equedical expenses must be primarily to the include expenses that are merely lexpenses include the premiums you patts you pay for transportation to get mangeterm care services and limited amounts.	nipment, supp alleviate or poeneficial to g ay for insuran edical care. N	lies, and diagraphysics and physics displayed by the control of the covers of the cove	iostic devices ical or ment a, such as vi the expenses ses also inclu	s needed for tal defect or tamins or a s of medical ade amounts
Item	Family Member	Type of Medical Expense	Frequency of Appt. / Payment	Family Cost per Appt. / Payment	Current Balance (if applicable)	Housing Authority Use
1.		Regular Appt. Unpaid Balance				
I hereb has an paymen	y certify that the unpaid balance v	the definition of an allowable expense, as dependent person named above has allowable expenses for the payment plan, and that the frequency and to the best of my knowledge.	for appointments			
	•	Pho	ne:			
с. Тур	e of health care p	provider:				
of the ex	penses listed abo	information is true, correct, and complete, and ove. Warning – Title 18 Section 1001 of the and willingly making false or fraudulent sta	United States C	ode states that a	ny person wou	ld be guilty of
X Print	Name of Head	of Household Signature			Date	



Head of Household:

MEDICAL EXPENSE VERIFICATION FORM

Out of Pocket / Unreimbursed Expenses for: MEDICAL INSURANCE PREMIUMS

Tenant ID:

Item	Family Member	Name and Address of Insurance Company / Agency that you pay a premium to	# of Times Per Year	Family Cost per Payment	Housing Authority Us
1.					
2.					
3.					
4.					
5.					
or any VARN VOUI	portion of the NING – TITILD BE GUI	this information is true, correct, and complete, expenses listed above. LE 18 SECTION 1001 OF THE UNITED STATE OF A FELONY FOR KNOWINGS ATEMENTS TO ANY DEPARTMENT OR	STATES CODE S LY AND WILLIN	TATES THAT AN	NY PERSON FALSE OF
c					

Use the form below to record information about any <u>un-reimbursed</u>, <u>out of pocket</u> medical premiums that you pay on a regular ongoing basis. The information on this form must be accompanied by a current **original** copy



MEDICAL EXPENSE VERIFICATION FORM

Out of Pocket / Unreimbursed Expenses for: ANTICIPATED ONE TIME EXPENSES

Head of Househol	d:	Tenant ID:			
which you will no	w to record information about any anticipated, one time return be reimbursed for, and which you pay out of pocket. As a surgery or procedure) or supplies / equipment (such a	nticipated one tir			
	lowable Medical Expense: Medical expenses ar revention of disease, and the costs for treatment				
other medical prathese purposes. illness. They do vacation. Medicare, and the amo	nclude payments for legal medical services rendered actitioners. They include the costs of equipment, support include expenses must be primarily to alleviate or period include expenses that are merely beneficial to call expenses include the premiums you pay for insurpounts you pay for transportation to get medical care. It long-term care services and limited amounts paid for the premiums are services and limited amounts paid for the premium in the prem	pplies, and diagorevent a physico general healt ance that cover Medical exper	nostic devices n al or mental defe th, such as vitar is the expenses o uses also include	eeded for ect or nins or a f medical amounts insurance	
Family Member	Type of Medical Expense	Family Cost	Scheduled / Expected Date	Housing Authority Use	
	☐ Treatment / Procedure ☐ Equipment / Maintenance				
Do you expect to	pay in full, or have a payment plan? Pay in Full	Payment Pl	an		
If you expect a pa	ayment plan, please state the expected frequency and amount	ount of payments	5.		
Frequency of Pay	ments: Amount per Paymer	nt:			
_	e meet the definition of an allowable expense, as define the person named above has scheduled or anticipates		Yes No		
•	nd scheduled or expected date are accurate to the best of		onso, and that		
a. Medical Grou	p / Office:				
b. Name:	Phone:				
c. Type of health	care provider:				
for any portion of any person would	at this information is true, correct, and complete, and the expenses listed above. Warning – Title 18 Section does not be guilty of a felony for knowingly and willingly nearly of the United States.	n 1001 of the U	nited States Cod	le states that	
x					
Print Name of H	lead of Household Signature		Date		



MEDICAL EXPENSE VERIFICATION FORM

Out of Pocket / Unreimbursed Expenses for: Transportation / Mileage to Health Care Appointments

OFTHE	COUNTY OF SANTA CRUZ	isportation / 111ti	euge to meat	iii Cai c rippo	, cittiite itts
Head of	Household:		To	enant ID:	
	form below to record information at are appointments, which you will no	•	•		ly scheduled
	ion of Allowable Medical Expe ent, or prevention of disease, a	_		_	
other methese pillness. vacation care, an	expenses include payments for landical practitioners. They include urposes. Medical expenses must be a made the medical expenses include expenses include expenses include the medical expense	de the costs of equipment be primarily to alle that are merely bender premiums you pay for portation to get medical.	nent, supplies, and viate or prevent eficial to general or insurance that al care. Medical	d diagnostic device a physical or me health, such as covers the expense expenses also income	ces needed for ental defect or vitamins or a ses of medical clude amounts
Item #	Location of Appointment (Full A	ddress) Frequ	ency	Complete Number of Miles (round trip)	Mileage(HA use
1.				•	
2.					
3.					
4.					
5.					
6.					
for any any per	certify that this information is true portion of the expenses listed above con would be guilty of a felony forment or agency of the United States	e. Warning – Title 18 S or knowingly and willin	Section 1001 of th	e United States Co	ode states that
X Print	Name of Head of Household	Signatura		Data	
Print	manie of Head of Household	Signature		Date	