

## Medical Expense Allowance Information Packet \*\*HARDSHIPS ONLY\*\*

#### **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 in 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.

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#### 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. Medications 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 Premiums</u> 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 aids, 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 o	f Household:		Tenant ID:			
	Jse the form below to record information about each medication that you have an ongoing prescription for, which you vill not be reimbursed for, and which you pay out of pocket.					
		e Medical Expense: Medical expenses a on of disease, and the costs for treatme		_	_	
other in these pillness vacation care, a	medical practition purposes. Medical They do not income. Medical expend the amounts yor qualified long-t	payments for legal medical services renders. They include the costs of equipment, I expenses must be primarily to alleviate clude expenses that are merely beneficianses include the premiums you pay for in you pay for transportation to get medical coverm care services and limited amounts pair	supplies, and de or prevent a pal to general he surance that covere. Medical ex	iagnostic devices ohysical or ment ealth, such as vi- wers the expenses penses also inclu-	s needed for al defect or tamins or a s of medical ide amounts	
Item	Name Of Family Member	Type of Medical 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 pose frequency of purceedge.	he definition of an allowable medication, as of erson named above receives an allowable medichase and un-reimbursed family cost per purchase	cation on an ongo	oing basis, and		
		Phone:				
	e of health care provide					
of the exa felony	xpenses listed above.  y for knowingly and	rmation is true, correct, and complete, and that I hav Warning – Title 18 Section 1001 of the United St willingly making false or fraudulent statements to ehold Signature Date	tates Code states tl	hat any person wou	ld be guilty of	
1 1 1111 IN	unic or ricau or rious	onora orginature Date				

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

Head of Household:			Tenant ID:			
unpaid Informa	Use the form below to record information about any ongoing, regularly scheduled health care appointments and / or any unpaid balances with payment plan agreements, which you will not be reimbursed for, and which you pay out of pocket. Information must be verified by a doctor or other health care provider to be considered as a valid medical expense for the purpose of the Medical Expense Deduction.					
		vable Medical Expense: Medical expension of disease, and the costs for				
other rathese parties. vacation care, a	nedical practicular process. Med <b>They do not On.</b> Medical end the amount or qualified lo	dude payments for legal medical service tioners. They include the costs of equidical expenses must be primarily to a tinclude expenses that are merely be expenses include the premiums you pay its you pay for transportation to get meng-term care services and limited among	ipment, suppl illeviate or p eneficial to g y for insurance edical care. N	lies, and diagnorevent a physiceneral health ce that covers Medical expens	ostic devices ical or ment s, such as vio the expenses ses also inclu	s needed for al defect or tamins or a s of medical ide 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	y certify that the unpaid balance v	t the definition of an allowable expense, as desperson named above has allowable expenses for with a payment plan, and that the frequency and to the best of my knowledge.	or appointments	on an ongoing ba		
a. Med	ical Group / Offi	ice:				
b. Nam		Phone			-	
с. Туре	e of health care p	provider:			_	
of the ex	penses listed ab	information is true, correct, and complete, and tove. Warning – Title 18 Section 1001 of the Uand willingly making false or fraudulent state	J <mark>nited States C</mark>	ode states that a	ny person wou	ld be guilty of
x	0.7-	Household Signature Date				
Print Na	ame of Head of I	Household Signature Date				

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## Out of Pocket / Unreimbursed Expenses for: MEDICAL INSURANCE PREMIUMS

Head o	of Household:		Tenant ID:				
pay or of you	n a regular ong	to record information about any <u>un-reimbugoing</u> basis. The information on this form material for payment to be considered as a valid me	ust be accompanion	ed by a current <b>ori</b>	ginal copy		
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 Use		
1.							
2.							
3.							
4.							
5.							
for any WARI WOUL	portion of the  NING - TITL  LD BE GUII	his information is true, correct, and complete, expenses listed above.  JE 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 OR		
x							
Print 1	Name of Head	of Household Signature Date					

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

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Head of Household: Tenant ID:				
which you will no	w to record information about any anticipated, one time not be reimbursed for, and which you pay out of pocket. And as a surgery or procedure) or supplies / equipment (such as	iticipated one tin		
	llowable Medical Expense: Medical expenses are prevention of disease, and the costs for treatment		_	_
other medical pr these purposes. I illness. <b>They do</b> <b>vacation.</b> Medic care, and the am	include payments for legal medical services rendered actitioners. They include the costs of equipment, sup Medical expenses must be primarily to alleviate or protinclude expenses that are merely beneficial to eal expenses include the premiums you pay for insuration ounts you pay for transportation to get medical care. In diagrams and limited amounts paid for the premium of the p	plies, and diagreevent a physica general healt ince that covers Medical expen	nostic devices no al or mental defe h, such as vitan s the expenses of ses also include I long-term care	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	o pay in full, or have a payment plan?  Pay in Full [	Payment Pla	n	
If you expect a p	ayment plan, please state the expected frequency and amo	ount of payments	S.	
Frequency of Payments: Amount per Payment:				
Does the expens	e meet the definition of an allowable expense, as define	ed above? 🗌 Y	es 🗌 No	
	hat the person named above has scheduled or anticipates and scheduled or expected date are accurate to the best of i		ense, and that	
a. Medical Group	o / Office:			
	Phone:			
c. Type of health	care provider:			
for any portion of any person would	nat this information is true, correct, and complete, and the f the expenses listed above. Warning – Title 18 Section d be guilty of a felony for knowingly and willingly magency of the United States.	n 1001 of the U	nited States Cod	le states that
x Distribution	d of Household Signature Date			
Print Name of Head	d of Household Signature Date			

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

	Transportation	n / Mueage to Head	un Care Appo	unimenis		
Head of	Household:	Tenant ID:				
	form below to record information about transportation are appointments, which you will not be reimbursed	0 1	on / mileage expenses for any ongoing, regularly scheduled for, and which you pay out of pocket.			
	ion of Allowable Medical Expense: Medical ent, or prevention of disease, and the costs	=	_			
other methese pillness. vacatio care, an	expenses include payments for legal medical nedical practitioners. They include the costs of purposes. Medical expenses must be primarily. They do not include expenses that are meron. Medical expenses include the premiums yound the amounts you pay for transportation to graph qualified long-term care services and limited to.	f equipment, supplies, and to alleviate or prevent ely beneficial to general ou pay for insurance that get medical care. Medical	d diagnostic device a physical or me health, such as covers the expense expenses also income	es needed for intal defect or vitamins or a ses of medical clude amounts		
Item #	Location of Appointment (Full Address)	Frequency	Complete Number of Miles (round trip)	Mileage(HA us		
1.						
2.						
3.						
4.						
5.						
6.						
for any any per departm	certify that this information is true, correct, and correction of the expenses listed above. Warning — reson would be guilty of a felony for knowingly ament or agency of the United States.	Title 18 Section 1001 of th	ne United States C	ode states that		