Medical Expense Allowance Information Packet

ELIGIBILITY

- You may request a Medical Expense Deduction 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 anticipated 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 services and limited amounts paid for any 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 cost 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. Medications – Use this form for prescription and over the counter medications.
   b. Health Care Appointments and Payment Plans – Use this form for any regular, ongoing appointments or unpaid balances that you are paying off with a payment plan.
   c. Medical Insurance Premiums – Use this form for your insurance premiums. *For this form only, please include a copy of your bill, or other proof of payment.*
   d. Anticipated One Time Expenses – 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 not 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: _____

Use 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.

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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			

Does the expense meet the definition of an allowable medication, as defined above? ☐ **Yes** ☐ **No**

I hereby certify that the person named above receives an allowable medication on an ongoing basis, and that the frequency of purchase and un-reimbursed family cost per purchase are accurate to the best of my knowledge.

a. Pharmacy / Office: _____

b. Name: _____ Phone: _____

c. Type of health care provider: _____

I hereby certify that this information is true, correct, and complete, and that I have not been, and will not be reimbursed for any portion of the expenses listed above. **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.**

x _____

Print Name of Head of Household Signature Date

MEDICAL EXPENSE VERIFICATION FORM
Out of Pocket / Unreimbursed Expenses for:
HEALTH CARE APPOINTMENTS / PAYMENT PLANS

Head of Household: _____ Tenant ID: _____

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.

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.

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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				
Does the expense meet the definition of an allowable expense, as defined above? ☐ **Yes** ☐ **No** I hereby certify that the person named above has allowable expenses for appointments on an ongoing basis, and / or has an unpaid balance with a payment plan, and that the frequency and un-reimbursed family cost per appointment or payment are accurate to the best of my knowledge. a. Medical Group / Office: _____ b. Name: _____ Phone: _____ c. Type of health care provider: _____						

I hereby certify that this information is true, correct, and complete, and that I have not been, and will not be reimbursed for any portion of the expenses listed above. **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.**

x _____

Print Name of Head of Household Signature Date

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

Head of Household: _____ Tenant ID: _____

Use the form below to record information about any un-reimbursed, out of pocket medical premiums that you pay on a regular ongoing basis. The information on this form must be accompanied by a current **original** copy of your bill, or proof of payment to be considered as a valid medical expense for the purpose of the Medical Expense Deduction.

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.					

I hereby certify that this information is true, correct, and complete, and that I have not been, and will not be reimbursed for any portion of the expenses listed above.

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.

X _____

Print Name of Head of Household Signature Date

MEDICAL EXPENSE VERIFICATION FORM

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

Head of Household: _____ Tenant ID: _____

Use the form below to record information about any anticipated, one time medical expenses for the next twelve months, which you will not be reimbursed for, and which you pay out of pocket. Anticipated one time expenses can include treatments (such as a surgery or procedure) or supplies / equipment (such as eyeglasses).

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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 Plan**

If you expect a payment plan, please state the expected frequency and amount of payments.

Frequency of Payments: _____ Amount per Payment: _____

Does the expense meet the definition of an allowable expense, as defined above? ☐ **Yes** ☐ **No**

I hereby certify that the person named above has scheduled or anticipates an allowable expense, and that the family cost and scheduled or expected date are accurate to the best of my knowledge.

a. Medical Group / Office: _____

b. Name: _____ Phone: _____

c. Type of health care provider: _____

I hereby certify that this information is true, correct, and complete, and that I have not been, and will not be reimbursed for any portion of the expenses listed above. **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.**

x _____

Print Name of Head of Household Signature Date

MEDICAL EXPENSE VERIFICATION FORM

Out of Pocket / Unreimbursed Expenses for:

Transportation / Mileage to Health Care Appointments

Head of Household: _____ Tenant ID: _____

Use the form below to record information about transportation / mileage expenses for any ongoing, regularly scheduled health care appointments, which you will not be reimbursed for, and which you pay out of pocket.

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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 services and limited amounts paid for any qualified long-term care insurance contract.

Item #	**Location of Appointment (Full Address)**	**Frequency**	**Complete Number of Miles (round trip)**	***Mileage(HA use only)***
1.				
2.				
3.				
4.				
5.				
6.				

I hereby certify that this information is true, correct, and complete, and that I have not been, and will not be reimbursed for any portion of the expenses listed above. **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.**

x _____

Print Name of Head of Household Signature Date