VERMONT
Department for Children and Families
Economic Services Division

120

3SquaresVT & Long Term Care
Medicaid Out-of-Pocket Medical Expenses

Head of Household (HOH) Name: _____

HOH Date of Birth: _____ HOH Social Security #: _____

The following medical expenses are for (list person's name): _____

For **3SquaresVT (3SVT)** applicants: Anyone in your 3SVT household who is **age 60 or older OR disabled** may be eligible for a standard medical expense deduction, which could increase the 3SVT benefit. To receive the standard deduction you must verify $35.01 per month of out-of-pocket medical expenses. If your out-of-pocket expenses are more than $173 per month, you may claim all medical expenses that you can verify.

I. Health Care Insurance Premiums, Co-pays, Deductibles, including those for Medicare and Medicaid that you pay out-of-pocket. Please provide proof of the plan, premium, cost and period covered.

Policy or type of coverage	Premium/Co-pay

II. Prescription co-pays: To have these expenses considered, please provide a printout from your pharmacy for the past 12 months that includes your name and SSN. This print out MUST show your cost.

III. Transportation: For 3SVT only: Out-of-pocket cost to obtain medical treatment or services. If you are using your own vehicle, please indicate the address where you are going. If service is being provided by a friend, hired service or public transportation, please list the amount you are actually paying instead of the destination. Please provide proof the trip took place for things such as (but not limited to), appointment cards for appointments, printout from pharmacy of dates you picked up prescriptions, receipts for a reasonable cost of transportation and/or lodging for medical services in the past 6-12 months. Please document medical trips on a separate paper and attach. For Long Term Care (LTC) please contact your worker if not covered by Medicaid.

IV. Medical Bills: Include current bills, bills you are paying on, and unpaid bills received in the past 12 months. Provide a current copy of your bill from the provider. Medical services can include services from the following (not a complete list):

- Physician
- Dentist
- Hospital care
- Nursing care
- Mental health professional
- Rehabilitation

Date of Service and Provider	Cost or monthly payment	Balance on bill

V. Other Medical Expenses: Out-of-pocket costs related to medically necessary services such as employing a home health aide or personal services attendant. Provide proof of the expense for the service that you still currently have or have had in the past 6-12 months. For a service animals specially trained to help disabled clients; please provide proof of costs to secure and maintain the animal(s), like food, vet bills and any special medicines or diets. For employing an aide or attendant; a statement or bill and verification of payment. For LTC Medicaid additional verification may be required.

Type of Service	Cost and Frequency (weekly, monthly)

VI. Over the Counter Medications, Equipment, and Supplies *approved by a health professional*: For 3SVT only: Please provide proof that the health professional recommends you use this (signature at the bottom of this) or a recent statement from the health professional. List items such as (but not limited to) the examples listed below:

- Eyeglasses
- Hearing aids
- Medical batteries
- Pain relievers
- Eye/Ear drops
- Vitamins
- Antacids
- Sleeping aids
- Denture supplies
- Bladder control pads and/or garments
- Anti-diarrhea medicine
- Nasal sprays

Medication or item	Dose (number of pills per day, tubes per month, etc.)

FOR LONG TERM CARE APPLICANTS ONLY:

I give my word that the information I give on this form is true and complete to the best of my knowledge and belief.

Signature _____ Date _____

FOR HEALTH PROFESSIONAL ONLY:

If you are verifying anything in section VI, please sign here to verify you have recommended the OTC.

Provider name (please print) _____ Provider number _____

Address _____ Telephone number _____

_____

Provider Signature _____ Date _____