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 or Long Term Medicaid** 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 |
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**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**: 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.

**IV. Medical Bills:** Include current bills, bills you are paying on, and unpaid bills that you are still responsible for. 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 |
|---|---|---|
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**V. Other Medical Expenses:** Out-of-pocket costs related to a certified service animal, as well as costs for 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 animal; certification paperwork for the certified service animal, any vet bills associated with the animal and receipts for dog food. For employing an aide or attendant; a statement or bill and verification of payment.

| Type of Service | Cost and Frequency (weekly, monthly) |
|---|---|
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**VI. Over the Counter Medications, Equipment, and Supplies *approved by a health professional*:** 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.) |
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**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 ______________