Department of Housing Preservation & Development

Division of Tenant Resources

HEAD OF HOUSEHOLD NAME	SOCIAL SECURITY NUMBER (last 4 digits)

FORM 6. DECLARATION OF UN-REIMBURSED MEDICAL & PHARMACY EXPENSES

	Have you completed this form?	
If the Head of Household, co-head, or spouse is disabled, and/or 62 years of age or older and has **un-reimbursed** (not already paid for by someone other than yourself) medical or pharmacy expenses, please complete this form for each household member with medical or pharmacy expenses. You must submit verification of all un-reimbursed medical and pharmacy expenses incurred during the last 12 months if they are expected to be an expense in the upcoming year. This includes copies of cancelled checks, receipts, or statements from an insurance company. Please submit a pharmacy printout for any un-reimbursed prescription payments you have made in the past 12 months. **TO BE COMPLETED AND SIGNED BY THE HEAD OF HOUSEHOLD**	**Yes** ☐	**Not Applicable** ☐

Is Your Household Eligible for a Medical Expense Deduction?

1. Do you have any un-reimbursed pharmacy expenses? ☐ Yes ☐ No
2. Do you pay a Medicare premium or pay for medical insurance? ☐ Yes ☐ No
3. Is any family member currently paying off past medical bills? ☐ Yes ☐ No
4. Is there an anticipated medical expense during the next 12 months? ☐ Yes ☐ No

If you answered yes to any of the questions above, please complete the box below:

Name of Household Member	**Eligible Expense** (pharmacy, insurance premiums, dental, hearing aid, eyeglasses, medical equipment)	**Amount Due, Paid in the Past, or Expected in the Next 12 Months*** (Submit proof of payment or invoice)	**Expense Date or Payment Frequency** (monthly, annually, etc.)	**Name and Phone Number of Institution Providing Service**

*If copies of cancelled checks, receipts, or statements from an insurance company are not available, you may submit a statement from your doctor, pharmacist, or other medical-related service provider specifying the nature and amount of expenses expected in the next 12 months. Only the portion of the total medical expense that exceeds 3% of the household annual income is an allowable deduction.

I certify that the above information is accurate and understand that providing false statements to a government agency is punishable under federal law and may result in loss of subsidy.

_____ _____/_____/_____

SIGNATURE OF HEAD OF HOUSEHOLD **DATE**

Printed on paper containing 30% post-consumer material.