HomeFront
Partners for a Better Billings

SECTION 8 HOUSING CHOICE VOUCHER

MEDICAL EXPENSE WORKSHEET

Name:

Date:

PROVIDE ANTICIPATED MEDICAL EXPENSES FOR THE NEXT 12 MONTHS ONLY

PERSCRIPTIONS Name of company / Pharmacy	RX#	AMOUNT PAID	CONTINUES FOR NEXT 12 MO.		CHECK ONE				WHO IS EXPENSE PAID FOR (Self, spouse, child, etc.)	OFFICE USE ONLY Allowable Deduction
			Y	N	30-days	60-days	120-days	OTHER		
Example: Walgreens	1767	$3.95	Y					90 DAYS	Self	

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Name:

Date:

INSURANCE Provider/Description	**MONTHLY AMOUNT BILLED**	**CONTINUES FOR NEXT 12 MO.**		**NAME OF PROVIDER**	**WHO IS EXPENSE PAID FOR** (Self, spouse, child, etc.)	**OFFICE USE ONLY Allowable Deduction**
		Y	**N**			
MEDICARE (PART B)						
MEDICARE (PART D)						
PRIVATE MEDICAL INSURANCE						
PRIVATE MEDICAL INSURANCE						

MEDICAL EXPENSE (Physician or Hospital Charges, Eyeglasses, Oxygen Rental, Service/Companion Animal expenses* etc.) *MUST HAVE ASSOCIATED APPROVED REASONABLE ACCOMODATION	**BALANCE OWED / CO-PAY or AMOUNT PAID**	**CONTINUES FOR NEXT 12 MO.**		**ANTICIPATED EXPENSE** How often will expense be incurred?	**WHO IS EXPENSE PAID FOR** (Self, spouse, child, etc.)	**OFFICE USE ONLY Allowable Deduction**
		Y	**N**			
Example: St. Pete's Hospital	*$1,000*	*y*		*$25 monthly until paid in full*	*Self*	
Example: Cat food	*$10.50*	*y*		*Twice a month*	*Self*	