Human Resources Administration
Department of Social Services

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

FORM 4. DECLARATION OF UNREIMBURSED MEDICAL & PHARMACY EXPENSES

If the Head of Household, co-head, or spouse is disabled, and/or 62 years of age or older and has **unreimbursed** (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 unreimbursed 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 unreimbursed prescription payments you have made in the past 12 months.

TO BE COMPLETED AND SIGNED BY THE HEAD OF HOUSEHOLD

Is Your Household Eligible for a Medical Expense Deduction?

1. Do you have any unreimbursed pharmacy expenses? □ Yes □ No
2. Do you pay a Medicare premium or pay for medical insurance? □ Yes □ No
3. Is any household 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 and pharmacy expenses and disability expenses (Form 5) 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 HRA HOME TBRA benefits.

_____ _____/_____/_____

SIGNATURE OF HEAD OF HOUSEHOLD **DATE**