

<b>HEAD OF HOUSEHOLD NAME</b>	<b>SOCIAL SECURITY NUMBER (last 4 digits)</b>
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**FORM 5: DECLARATION OF UNREIMBURSED DISABILITY EXPENSES**

If your household has an unreimbursed expense for attendant care (home health aide for a disabled adult or babysitter for a disabled child aged 13 or older) or medical equipment (such as a wheelchair) for a household member who is disabled and, as a result of this expense, you or any household member were able to earn income from a job, you should complete this form. You must submit verification of any disability expenses incurred during the last 12 months. This may include a receipt for a wheelchair, ramp, adaptation to a vehicle, or special equipment to enable a blind person to read and write.

**TO BE COMPLETED AND SIGNED BY THE HEAD OF HOUSEHOLD**

**Is Your Household Eligible for a Disability Expense Deduction?**

1. Do you pay for someone to care for a disabled person in your household?  Yes  No
2. Did you buy medical equipment for a disabled person in your household?  Yes  No
3. Were you or any household member able to earn income from a job because of this disability expense?  
 Yes  No

If you answered yes to question #3 above, please complete the boxes below:

	<b>Name of disabled household member:</b>	<b>Name of disabled household member:</b>
	1. _____	2. _____
<b>Eligible disability expense(s):</b> (medical equipment or attendant care expense)		
<b>Amount due or expected in the next 12 months:</b> (Submit proof of recurring payments or invoice)		
<b>Name(s) and phone number of institution(s) providing service:</b>		
<b>Name(s) of household member(s) who earned income as a result of the disability expense:</b>		

Note: Only the portion of the total disability expenses and medical and pharmacy expenses (Form 4) that exceeds 3% of your household annual income is an allowable deduction. The deduction for the disability expense may not exceed the total amount of money earned by the household member(s) who are able to work because of the disability expense.

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.

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**SIGNATURE OF HEAD OF HOUSEHOLD** **DATE**