Head of Household's Name:

THIS FORM IS FOR ELDERLY/DISABLED HEAD OF HOUSEHOLD, SPOUSE, OR PARTNER ONLY

Elderly and disabled participants who are the head of household, spouse, or partner are entitled to certain benefits regarding medical expenses (NOTE**:** medical can include chiropractors, naturopaths, dentists, eye care, etc).
In order to be eligible for this benefit, you must meet one of the following definitions.

Elderly: A person at least 62 years of age.

Disabled: A person who: **a.** has a disability as defined in section 223 of the Social Security Act, **b.** has a physical, mental, or emotional impairment that: **(I)** is expected to be of long-continued and indefinite duration, **(II)** Substantially impedes his/her ability to live independently; and (**III**) is of such a nature that ability to live independently could be improved by more suitable housing conditions, and **c.** has a developmental disability as defined in section 102(7) of the Developmental Disabilities Assistance and Bill of Rights Act.

1. Is the head of household, spouse or co-head elderly or disabled? ☐ YES ☐ NO
   If **YES**, please continue completing this form
   If **NO**, STOP. Do not complete this form.
2. Do you pay medical expenses out-of-pocket for any household member? ☐ YES ☐ NO
   If **YES**, please continue completing this form
   If **NO**, STOP. Do not complete this form.
3. Do you expect to pay more than 3% of your gross annual income for medical expenses? ☐ YES ☐ NO
   If **YES**, please provide requested information in the table below.
   If **NO**, STOP. Do not complete this form.

4. Do you pay for any medical, dental, or optical insurance for any family member? ☐ YES ☐ NO
   If you pay for Medicare, please include below.
   If **YES,** please list and provide verification of each premium.

Family Member	Provider's Name, Mailing Address, Phone Number & Fax Number	Policy #	Premium
Family Member's Name	Insurance Provider's Name Address Phone Fax	Policy #	$ Premium Monthly ☐ Quarterly ☐ Annually ☐
Family Member's Name	Insurance Provider's Name Address Phone Fax	Policy #	$ Premium Monthly ☐ Quarterly ☐ Annually ☐

5. Do you have a spenddown for Medicaid? ☐ YES ☐ NO
   If **YES**, Please provide your letter of verification from DSHS. Amount $_____.

6. Do you pay prescription costs for any family member not covered by insurance? ☐ YES ☐ NO
   If **YES**, complete area below and submit 12 month pharmacy printout.

Family Member	Pharmacy Name, Mailing Address, Phone Number & Fax Number	Amount Spent
Family Member's Name	Pharmacy Name Address Phone Number Fax Number	Average $ Spent $_____/mo.
Family Member's Name	Pharmacy Name Address Phone Number Fax Number	Average $ Spent $_____/mo.

7. Are you making regular payments to any doctor or medical facility for any family member? ☐ YES ☐ NO
Have you paid out of pocket to visit your medical provider within the last twelve months? ☐ YES ☐ NO
Do you expect to have future ongoing medical expenses with a specific provider? ☐ YES ☐ NO
If **YES**, please complete below and submit verification(s).

Family Member	Doctor/Medical Facility Name, Mailing Address, Phone Number & Fax Number	Payment Amount
	Doctor/Medical Facility Name	$_____/mo.
Family Member's Name	Address	Balance owed $
	Phone Fax	Co-pay per visit $_____.
	Doctor/Medical Facility Name	$_____/mo.
Family Member's Name	Address	Balance owed $
	Phone Fax	Co-pay per visit $_____.
	Doctor/Medical Facility Name	$_____/mo.
Family Member's Name	Address	Balance owed $
	Phone Fax	Co-pay per visit $_____.

8. Do you currently pay or anticipate paying for a care attendant? ☐ YES ☐ NO
If **YES**, please provide verification of your need for the care attendant, receipts and list the amount you pay. **$**

9. Do you currently pay or anticipate paying for medical equipment? ☐ YES ☐ NO
(i.e. a wheelchair)
If **YES**, please provide verification of your need for the medical equipment, receipts and list the amount you pay. **$**

10. Do you currently pay for unreimbursed, prescribed over-the-counter medicines? ☐ YES ☐ NO
If **YES**, please provide verification from your medical provider of your need for the over-the counter medicines, receipts and list the amount you pay. **$**

11. Do you currently pay for unreimbursed medically related travel expenses? ☐ YES ☐ NO
If **YES**, please provide documentation of your mileage, receipts and list the amount you pay. **$**

12. Do you currently pay for unreimbursed service animal related expenses? ☐ YES ☐ NO
If **YES**, please provide documentation from your medical provider of your need for a service animal, receipts and list the amount you pay. **$**

I hereby declare that the information provided by me in this form is truthful to the fullest extent of my knowledge and belief. I understand that the Housing Authority of Thurston County will verify this information. I hereby give my permission to the Housing Authority of Thurston County to contact any individual or facility specifically indicated in this form or on any attached documentation for the purpose of verifying the validity of the information that I have provided. Such authorization lasts for a period of 120 days from the date signed below. I understand that false, misleading or incomplete information may be considered fraud and serve to disqualify me and my family from obtaining or maintaining our housing assistance.

_____ _____
Signature of head of household Date

If you need additional room on any of the boxes on this form, please attach on a separate piece of paper.

Please note: If you do not include all of the current contact information (including name, address, phone number & fax number) for your insurance provider, medical provider, pharmacy or care attendant, HATC may not be able to verify and/or include your medical deductions when calculating your tenant rent share.