Read These Instructions Prior to Completing the "Unreimbursed Medical Expense Form"

**It is important that you review the Georgia CAFE brochure about the Standard Medical Expense Deduction (SMED) before you complete this form.

1. After reviewing the SMED brochure, determine if you have more than $35.00 in unreimbursed medical expenses. If so, continue with these steps.
2. If the medical expense(s) to be submitted to DFCS do(es) not total more than three expenses and do not include transportation, these expenses can be entered directly onto the SNAP application for new applicants.
3. If your client is a current SNAP recipient or a new applicant whose case does not apply to the previous step's condition, this form will help in the organization and calculation of medical expenses and can be submitted to DFCS along with the needed verification.
4. **Remember, Georgia only requires that you provide verification of your medical expenses over $35.00 to qualify for the SMED. Only if you have more than $185/month, do you have to provide verification of expenses total more than this set amount to claim a higher deduction.**

Steps to Complete the "Unreimbursed Medical Expense Form"

1. Fill in the name of the client at the top of each page.

2. **Section A. Who are the Health Care Providers** (Medical/dental/eye care; Hospital/outpatient visits)? and

3. **Section B. What Pharmacies/Stores are used for over-the-counter or prescription medications?**
    a. These sections are great to complete to get you thinking about potential medical expenses you have. You only need to complete this information about your health providers or pharmacy, if you need DFCS to verify a medical expense on your behalf or you are planning to submit mileage for trips to and from your health providers or your pharmacy. Remember you can submit a statement of your travel stating to and from locations with an approximation of mileage.

4. **Section C. What are the Transportation Costs to doctor's offices, pharmacies, hospitals, etc.?**
    a. Though a statement is sufficient, this section can be completed for you to get a total of your mileage and to calculate your monthly cost using the current federal mileage rate, currently set at 0.545 cents/mile.

5. **Section (1). Transportation Costs continued**
    a. Transfer the total number of miles you have calculated in Section C and use the provided calculation to get a monthly total. (Total Miles Driven) x (Mileage Rate ($0.54/mi)). Transportation includes taxi or other driver fees such as parking costs. Add together all transportation costs and then divide that total by 12.

6. **Section (2). Health Care Premiums**
    a. Government and private health care premiums and supplements should be included here. A common and simple way to qualify for the SMED, is the submission of verification of Medicare ($104.90/month). Take each applicable premium and divide it by 12. The name of the premium or supplement should be listed followed by the monthly total in the last column.

7. **Section (3). Doctor/hospital visits (co-payments):**
    a. In the column of type of expense, you can write doctor or hospital visit. Your provider should be one of the one's you listed on page 3. Note in the 3rd column, the amount of the co-payments made in one year. Remember to divide the amount by 12 to get a monthly total.

8. **Section (4). Co-payments for prescriptions medications:**
    a. In the column of type of expense, you can write doctor or hospital visit. Your provider should be one of the one's you listed on page 3. Note in the 3rd column how often in a year you make the expense. In the 4th column, write the amount of the co-pay. Remember to multiply the 3rd and 4th column values and to divide it by 12 to get a monthly total.

9. **Section (5). Over-the-counter (OTC) medications/products:**
    a. In the column of type of expense, you can write doctor or hospital visit. Your provider should be one of the one's you listed on page 3. Note in the 3rd column how often in a year you make the expense. In the 4th column, write the cost of the medicine/product. In the 5th column note how many were purchased. Remember the goal is to get the total amount spent and to divide it by 12 to get a monthly total.

10. **Section (6). Dental bills:**
    a. In the 1st column, write what service was provided. The 2nd column, should be one of your provider should be one of the one's you listed on page 3. Note in the 3rd column, the amount of the co-payments made in one year. Remember to divide the amount by 12 to get a monthly total.

11. **Section (7). Unpaid medical bills currently being billed for:**
    a. Any medical services provided by a health care provider, that you are being ***actively billed*** for can be included here. The medical bill should clearly state who the provider was, what service was provided, and the date of service. Divide the "Amount owed" by 12 to get the monthly total.

12. **Section (8). Other expenses (cost of eyeglasses, medical supplies):**
    a. Include other medical expenses such as those listed in the Georgia CAFE brochure that you have as reoccurring expenses or that you are actively being billed for. Divide the "Amount of Bill" by 12 to get the monthly total.

13. Submit the completed form along with the supporting verification/documentation to DFCS along with the completed SNAP application if the client is a new applicant. If the client is a current SNAP recipient, the information can be submitted the same way they applied or renew his or her benefits.

Unreimbursed MEDICAL EXPENSES (Include with SNAP Application)

Client Name:

A. Who are your Health Care Providers (Medical/dental/eye care; Hospital/outpatient visits)?

Name	Phone Number	Address for Office of Provider	How often provider is seen?

B. What Pharmacies/Stores are used for over-the-counter or prescription medications?

Pharmacy/Store Name	Phone Number	Address for Pharmacy/Store	How often visited?

C. What are the Transportation Costs to doctor's offices, pharmacies, hospitals, etc.?

Drive him/her-self? Yes No Does client pay someone to drive them? Yes No

If Yes, who? (Include contact info)

How much?

Purpose of Trip	Miles per Visit	How often?	Total Miles	Purpose of Trip	Miles per Visit	How often?	Total Miles

Total Miles Driven for all Visits per Year	

Unreimbursed MEDICAL EXPENSES (Include with SNAP Application)

Client Name:

	Monthly Totals
(1) Transportation costs (Use Total Miles from Page 3): (Total Miles Driven) x (Mileage Rate ($0.54/mi)); Include Taxi and Other Driver Fees Here	
(2) Healthcare premiums (e.g. Medicare Part B = $104.90):	

(3) Doctor/hospital visits (co-payments):

Type of Expense	Provider	Amount	

(4) Co-payments for prescriptions medications:

Type of Expense	Provider	How Often Expense Made	Amount of Co-pay	

(5) Over-the-counter (OTC) medications/products:

Type of Expense	Provider	How Often Expense Made	Cost of OTC med/product	Quantity	

Unreimbursed MEDICAL EXPENSES (Include with SNAP Application)

Client Name:			
(6) Dental bills:			
Type of Expense	**Provider**	**Amount of Bill**	
(7) Unpaid medical bills currently being billed for:			
Type of Expense	**Provider**	**Amount Owed**	
(8) Other expenses (cost of eyeglasses, medical supplies):			
Type of Expense	**Provider**	**Amount of Bill**	
Sum of monthly totals for sections (1), (2), (3), (4), (5), (6), (7), and (8)		**Total**	
Only medical expenses totaling more than $35.00/month qualify for the SMED*			**-$35 =**
		Grand Total	

***SMED = Standard Medical Expense Deduction**

I am requesting DFCS to assist me in the verification of these expenses.

_____ _____

Signature of Client Date