VERMONT
DEPARTMENT FOR CHILDREN & FAMILIES
ECONOMIC SERVICES DIVISION

120

3SquaresVT and 3SquaresVT in a SNAP
Out-of-Pocket Medical Expenses

Head of Household (HOH):_____ **HOH Social Security #:**_____
First and last name Last 4 digits

The medical expenses being claimed are for:_____
First and last name of person claiming medical expenses

You may claim a deduction for medical expenses if a household member:

- Is at least 60 years old or disabled, AND
- Has out-of-pocket medical expenses.

Getting this deduction could increase your 3SquaresVT or 3SquaresVT in a SNAP benefit.

---

1. **Healthcare insurance premiums:** include Medicare and VPharm premiums paid for out-of-pocket**.** Provide a receipt showing the amount paid and how often.
2. **Prescription co-pays:** Provide a printout from the pharmacy for the past 12 months.
3. **Transportation costs for medical treatment/services from the past 12 months**: Provide proof of the trips made (e.g., appointment cards and medical bills).
   - If you used your own vehicle, provide the physical address of the appointments, and note that you drove yourself.
   - If transportation was provided by someone else or public transportation was used, provide confirmation of the amount paid.
4. **Medical bills, copayments, and deductibles:** Provide copy of current bills, bills being paid on, and unpaid bills received in the past 12 months. Indicate on the bill if it is an ongoing or one-time expense. If it's ongoing, note how often. Examples of medical services: physician, dentist, hospital, nursing care, rehabilitation, mental health professional.
5. **Other medical expenses:** This includes paying for a home health aide or personal services attendant. Provide proof of expenses from the past 12 months. Indicate if it's an ongoing or one-time expense. If ongoing, note how often.
6. **Service animals:** Describe the services provided and training received. Provide proof of costs to buy and care for the animal (e.g., food, veterinary care, special medications).
7. **Over-the-counter medications (OTC), equipment, and supplies *approved by a health professional*:** Provide proof a health professional recommended their use by having them sign the bottom of this form or providing a written statement.

   Examples of OTCs: vitamins, denture supplies, pain relievers, eye drops, antacids, sleeping aids, bladder control pads/garments, nasal sprays. Examples of equipment: eyeglasses, contact lenses, wheelchair, cane, dentures, hearing aids. Provide a receipt for medical equipment.

****Please continue on the other side****

If proven expenses are between $35.01 and $191 per month, you'll get the standard deduction of $156. If they are over $191 per month, you may claim all the expenses that can be proven over the first $35.

Medication or Item	**Dose and Frequency** *(number of pills per day, tubes per month, etc.)*
Example: Aspirin *Example: Allergy Eye Drops* *Example: Pain Relief Cream*	*Example: 1 pill per day* *Example: 1 – 2oz bottle per month* *Example: 1 tube every 2 months*

HEALTH PROFESSIONAL ONLY: Sign here to verify you've recommended the items in section 7.

Provider name (print):_____ Provider number:_____

Address:_____ Telephone number:_____

Provider Signature:_____ Date:_____

For help completing this form, call your local Council on Aging at (800) 642-5119.