



Food Stamp/SNAP Benefits for Elders/Disabled Households that Incur Medical Expenses

For All Seniors (age 60 or over) and Persons with Disabilities:

If you have out-of-pocket medical expenses, your SNAP benefits may increase! DTA allows a \$90 deduction from income if you have medical expenses **over \$35** per month. This deduction can increase your benefits. If you pay over \$125/month in expenses, you might get even more SNAP.

Q. What kinds of medical related expenses can I claim?

Basic Care costs...	If you pay directly for any medical, dental care, mental health, physical therapy, hospital based care, home health and nursing care. .. or if you pay any insurance premiums, co-payments or deductibles.
Alternative Care...	If you pay for acupuncture, chiropractic, homeopathy or herbal treatments prescribed by a licensed practitioner.
Health Care Supplies and Equipment...	If you buy special creams, ointments, pain magnets, incontinence supplies, commodes or other supplies and/or equipment recommended by your licensed health practitioner.
Over-the-counter drugs...	If you buy pain relievers, insulin, antacids, vitamins, allergy pills other remedies recommended by your health practitioner.
Mileage at 55.5 cents/mile or the cost of public transport...	If you drive your car to appointments <u>or</u> to pick up drugs or medical supplies at the pharmacy, you can claim 55.5 cents per mile driven -- or what you pay for a taxi, bus, subway or train.
Housekeeper and caregiver expenses...	If you need a housekeeper or care attendant to care for you because of your age or disability.
Vision or hearing care communication devices, other one-time expenses...	If you buy eyeglasses, contacts, hearing aides, speech or communication equipment, or have monthly usage fees, OR you pay emergency medical care not covered by insurance.

Q. Is there a limit or cap on the expenses I can claim?

► If you have proof of medical expenses over \$35/month, DTA will automatically allow a standard \$90 deduction. You need to show proofs of at least \$35.01 /month to get this \$90 deduction.

► If you have more than \$125/month in un-reimbursed medical expenses, DTA will deduct the actual amount of these expenses in calculating your income (after the first \$35). There is **no cap** on what you can claim as an expense if you have proof of your un-reimbursed health-care expenses.

For example: Jane Smith is 78 and lives in public housing. She receives \$800 in Social Security, plus MassHealth. She gets only \$16/month in SNAP. Mrs. Smith drives to 20 miles/week to the doctor and pharmacy. Because she has over \$35/month in medical related transportation (86 miles x 55.5 cents = \$44.73) her SNAP benefits will increase to \$29/month.

Q. How do I claim medical expenses?

You can claim medical expenses on your application, or you contact your DTA worker. Be sure to keep copies of bills you pay, appointment letters that show the dates you travel. A sample checklist is on the back to help you keep track.

Mass. Law Reform Institute

FOOD STAMP/SNAP MEDICAL DEDUCTIONS CHECKLIST

MEDICAL CARE NOT REIMBURSED BY

INSURANCE (e.g., doctor/clinic visits, dental care, psychotherapy, rehabilitation, hospital or outpatient care, nursing or home health care)

Type of care	Cost/Month
	\$
	\$

HEALTH INSURANCE (e.g., premiums, co-payments, deductibles)

Type of cost	Cost/Month
	\$
	\$

ALTERNATIVE HEALTH TREATMENTS (e.g., chiropractic, acupuncture, massage therapy, Christian Science healing)

Type of treatment	Cost/Month
	\$
	\$

TRANSPORTATION/LODGING TO OBTAIN MEDICAL TREATMENT OR SERVICES (e.g., mileage for use of your private car *at 55.5 cents per mile*; actual cost of bus, subway, shuttle, or taxi)

Type of transportation	Cost/Month
	\$
	\$

PRESCRIPTION MEDICATION

Type of medication	Cost/Month
	\$
	\$
	\$
	\$
	\$

OVER-THE-COUNTER MEDICATION PRESCRIBED BY A HEALTH CARE PROVIDER (e.g., pain relievers, antacids, vitamins, insulin, herbal supplements)

Type of medication	Cost/Month
	\$
	\$
	\$

HEALTH-RELATED SUPPLIES PRESCRIBED BY A HEALTH CARE PROVIDER (e.g., foot care, incontinence supplies, dentures, hearing aides, batteries for hearing aides/other medically-related devices, eyeglasses, contacts, contact lens cleaning supplies)

Type of supply	Cost/Month
	\$
	\$
	\$
	\$
	\$

HEALTH EQUIPMENT (e.g., sick room equipment, purchase/repair of wheelchair or mobility aid, prosthetics, personal emergency response system, communication equipment for the hearing, speech or visually impaired)

Type of equipment	Cost/Month
	\$
	\$
	\$

OTHER EXPENSES (e.g., securing and maintaining service animals, attendant services, housekeeper)

Type of expense	Cost/Month
	\$
	\$
	\$

TOTAL COST OF MEDICAL EXPENSES PER MONTH: \$

I certify that I incur the medical expenses listed above. I have attached the receipts I have available. I request that the Department of Transitional Assistance consider these expenses when calculating my monthly SNAP benefits, and assist me with getting any additional proofs required.

X _____
Signature

Date

Printed Name

Agency ID (if known)