

Out-of-Pocket Medical Expenses Form

Massachusetts Department of Transitional Assistance



Instructions: Anyone who is 60 or older or gets benefits for a disability can submit out-of-pocket medical expenses to DTA. Please complete the entire form. Only write down information you have. We will tell you if we need more information. Please use a new form for each person in your SNAP case who qualifies. If you need more space, attach a sheet of paper.

The information I am giving is true and complete to the best of my knowledge.

Name of person age 60+ or disabled

DTA Agency ID

Your signature

Date

You may give this information to DTA in any of the following ways:

- **Online:** DTACConnect.com or DTA Connect Mobile App
- **Phone:** DTA Assistance Line at 877-382-2363
- **Mail:** DTA Processing Center, P.O. Box 4406, Taunton, MA 02780
- **Fax:** (617) 887-8765
- **In person:** Scan at a local DTA office

Repeating Medical Expenses

Co-payments

Cost

How often? (select one)

- | | | |
|---|----------|--|
| <input type="checkbox"/> Doctor, hospital | \$ _____ | <input type="checkbox"/> weekly <input type="checkbox"/> monthly <input type="checkbox"/> annually |
| <input type="checkbox"/> Dentist | \$ _____ | <input type="checkbox"/> weekly <input type="checkbox"/> monthly <input type="checkbox"/> annually |
| <input type="checkbox"/> Physical therapy | \$ _____ | <input type="checkbox"/> weekly <input type="checkbox"/> monthly <input type="checkbox"/> annually |
| <input type="checkbox"/> Chiropractor | \$ _____ | <input type="checkbox"/> weekly <input type="checkbox"/> monthly <input type="checkbox"/> annually |
| <input type="checkbox"/> Mental health services | \$ _____ | <input type="checkbox"/> weekly <input type="checkbox"/> monthly <input type="checkbox"/> annually |

Pharmacy costs

Cost

How often? (select one)

- | | | |
|--|----------|--|
| <input type="checkbox"/> Prescriptions | \$ _____ | <input type="checkbox"/> weekly <input type="checkbox"/> monthly <input type="checkbox"/> annually |
| <input type="checkbox"/> Over-the-counter drugs/supplies | \$ _____ | <input type="checkbox"/> weekly <input type="checkbox"/> monthly <input type="checkbox"/> annually |
| <input type="checkbox"/> Wound care supplies | \$ _____ | <input type="checkbox"/> weekly <input type="checkbox"/> monthly <input type="checkbox"/> annually |
| <input type="checkbox"/> Adult diapers | \$ _____ | <input type="checkbox"/> weekly <input type="checkbox"/> monthly <input type="checkbox"/> annually |
| <input type="checkbox"/> Vitamins and herbal health remedies | \$ _____ | <input type="checkbox"/> weekly <input type="checkbox"/> monthly <input type="checkbox"/> annually |

(Form continues on the other side.)

Medical supply costs		Cost	How often? (select one)
<input type="checkbox"/> Hearing aids/batteries		\$ _____	<input type="checkbox"/> weekly <input type="checkbox"/> monthly <input type="checkbox"/> annually
<input type="checkbox"/> Contact lenses		\$ _____	<input type="checkbox"/> weekly <input type="checkbox"/> monthly <input type="checkbox"/> annually
<input type="checkbox"/> Diabetes supplies		\$ _____	<input type="checkbox"/> weekly <input type="checkbox"/> monthly <input type="checkbox"/> annually
<input type="checkbox"/> Adhesives		\$ _____	<input type="checkbox"/> weekly <input type="checkbox"/> monthly <input type="checkbox"/> annually
Other health costs		Cost	How often? (select one)
<input type="checkbox"/> Home health or adult day care		\$ _____	<input type="checkbox"/> weekly <input type="checkbox"/> monthly <input type="checkbox"/> annually
<input type="checkbox"/> Gym membership		\$ _____	<input type="checkbox"/> weekly <input type="checkbox"/> monthly <input type="checkbox"/> annually
<input type="checkbox"/> Acupuncture or alternative medicine		\$ _____	<input type="checkbox"/> weekly <input type="checkbox"/> monthly <input type="checkbox"/> annually
<input type="checkbox"/> Service animal costs		\$ _____	<input type="checkbox"/> weekly <input type="checkbox"/> monthly <input type="checkbox"/> annually
<input type="checkbox"/> Housekeeping		\$ _____	<input type="checkbox"/> weekly <input type="checkbox"/> monthly <input type="checkbox"/> annually
Insurance Premiums: Provider Name		Cost	How often? (select one)
<input type="checkbox"/> Health: _____		\$ _____	<input type="checkbox"/> weekly <input type="checkbox"/> monthly <input type="checkbox"/> annually
<input type="checkbox"/> Drug: _____		\$ _____	<input type="checkbox"/> weekly <input type="checkbox"/> monthly <input type="checkbox"/> annually
<input type="checkbox"/> Other: _____		\$ _____	<input type="checkbox"/> weekly <input type="checkbox"/> monthly <input type="checkbox"/> annually
Travel (Non-driving)		Cost	How often? (select one)
<input type="checkbox"/> Taxis, rideshare (Uber, Lyft, etc.)		\$ _____	<input type="checkbox"/> weekly <input type="checkbox"/> monthly <input type="checkbox"/> annually
<input type="checkbox"/> Public transportation/The Ride		\$ _____	<input type="checkbox"/> weekly <input type="checkbox"/> monthly <input type="checkbox"/> annually
<input type="checkbox"/> Parking, tolls		\$ _____	<input type="checkbox"/> weekly <input type="checkbox"/> monthly <input type="checkbox"/> annually
Travel by car: For any medical appointments or pharmacy. There and back is 2 trips.			
Provider name and address (street, city)		Number of trips	How often? (select one)
Name: _____		_____	<input type="checkbox"/> weekly <input type="checkbox"/> monthly <input type="checkbox"/> annually
Address: _____			
Name: _____		_____	<input type="checkbox"/> weekly <input type="checkbox"/> monthly <input type="checkbox"/> annually
Address: _____			

Other One-Time Medical Expenses			
One-Time Costs	Cost	One-Time Costs (cont.)	Cost
<input type="checkbox"/> Glasses	\$ _____	<input type="checkbox"/> Communication equipment	\$ _____
<input type="checkbox"/> Wheelchair	\$ _____	<input type="checkbox"/> Medical procedure	\$ _____
<input type="checkbox"/> Walker	\$ _____	<input type="checkbox"/> Other _____	\$ _____
<input type="checkbox"/> Prosthetics	\$ _____	<input type="checkbox"/> Other _____	\$ _____
<input type="checkbox"/> Crutches	\$ _____		
<input type="checkbox"/> Dentures	\$ _____		