

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	\$ _____		