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**: DTAConnect.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)
☐ Doctor, hospital	$ _____	☐ weekly ☐ monthly ☐ annually
☐ Dentist	$ _____	☐ weekly ☐ monthly ☐ annually
☐ Physical therapy	$ _____	☐ weekly ☐ monthly ☐ annually
☐ Chiropractor	$ _____	☐ weekly ☐ monthly ☐ annually
☐ Mental health services	$ _____	☐ weekly ☐ monthly ☐ annually
Pharmacy costs	**Cost**	How often? (select one)
☐ Prescriptions	$ _____	☐ weekly ☐ monthly ☐ annually
☐ Over-the-counter drugs/supplies	$ _____	☐ weekly ☐ monthly ☐ annually
☐ Wound care supplies	$ _____	☐ weekly ☐ monthly ☐ annually
☐ Adult diapers	$ _____	☐ weekly ☐ monthly ☐ annually
☐ Vitamins and herbal health remedies	$ _____	☐ weekly ☐ monthly ☐ annually

(Form continues on the other side.)

Medical supply costs	**Cost**	How often? (select one)
☐ Hearing aids/batteries	$ _____	☐weekly ☐monthly ☐annually
☐ Contact lenses	$ _____	☐weekly ☐monthly ☐annually
☐ Diabetes supplies	$ _____	☐weekly ☐monthly ☐annually
☐ Adhesives	$ _____	☐weekly ☐monthly ☐annually

Other health costs	**Cost**	How often? (select one)
☐ Home health or adult day care	$ _____	☐weekly ☐monthly ☐annually
☐ Gym membership	$ _____	☐weekly ☐monthly ☐annually
☐ Acupuncture or alternative medicine	$ _____	☐weekly ☐monthly ☐annually
☐ Service animal costs	$ _____	☐weekly ☐monthly ☐annually
☐ Housekeeping	$ _____	☐weekly ☐monthly ☐annually

Insurance Premiums: Provider Name	**Cost**	How often? (select one)
☐ Health: _____	$ _____	☐weekly ☐monthly ☐annually
☐ Drug: _____	$ _____	☐weekly ☐monthly ☐annually
☐ Other: _____	$ _____	☐weekly ☐monthly ☐annually

Travel (Non-driving)	**Cost**	How often? (select one)
☐ Taxis, rideshare (Uber, Lyft, etc.)	$ _____	☐weekly ☐monthly ☐annually
☐ Public transportation/The Ride	$ _____	☐weekly ☐monthly ☐annually
☐ Parking, tolls	$ _____	☐weekly ☐monthly ☐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: _____	_____	☐weekly ☐monthly ☐annually
Address: _____		
Name: _____	_____	☐weekly ☐monthly ☐annually
Address: _____		

Other One-Time Medical Expenses

One-Time Costs	**Cost**	**One-Time Costs** (cont.)	**Cost**
☐ Glasses	$ _____	☐ Communication equipment	$ _____
☐ Wheelchair	$ _____		
☐ Walker	$ _____	☐ Medical procedure	$ _____
☐ Prosthetics	$ _____	☐ Other_____	$ _____
☐ Crutches	$ _____	☐ Other_____	$ _____
☐ Dentures	$ _____		