



Medicaid and 3SquaresVT Medical Expenses

Name _____ Date of birth _____ Social Security no. xxx-xx-_____
(Last four digits only)

For **3SquaresVT** applicants, list all monthly medical expenses for any household member who is age 60 or older or disabled. These expenses may reduce the household's income and possibly increase their 3SquaresVT benefits. Please complete this form and provide proof to have these expenses considered.

For **Medicaid** applicants, we may be able to use some of the same expenses to approve Medicaid eligibility. The rules for use of these expenses differ from 3SquaresVT. That means that some expenses may be used for 3SquaresVT eligibility but not for Medicaid.

Health Care Insurance Premiums – Please provide a copy of the premium showing cost and period covered.

Policy or type of coverage	Premium	Period covered

Prescription Costs – To have these expenses considered, please provide a printout from your pharmacy or pharmacy receipts for the last six months.

Over-the-Counter Medications, Equipment, and Supplies – Please include items such as:

- | | | | |
|----------------|------------------------|---------------|--------------------------------------|
| Pain relievers | Antacids | Eyeglasses | Bladder control pads and/or garments |
| Cold medicine | Laxatives | Hearing aides | Medical batteries |
| Vitamins | Anti-diarrhea medicine | Sleeping aids | Medical Lifeline services |

Medication or item	Dose (number of pills per day, tubes per month, etc.)	Cost and quantity (Cost of item and number in bottle)

For 3SquaresVT – Please have your medical provider complete the following section.

Have you recommended that this patient take the over-the-counter medications or use the supplies in the quantities listed above? Yes No

Provider's signature

Date

Print provider's name and practice

Phone number

