



## **RHA Simplified Medical Deduction Hardship Request**

The following is needed in order to fully determine eligibility for a hardship exemption:

- A detailed explanation of why the use of RHA's simplified medical deduction schedule has created a hardship.
- A list of all anticipated medical expenses for the upcoming year.
- Proof of medical expenses incurred over the past year (receipts, statements detailing amounts billed and paid, pharmacy printouts, etc.) to back-up the list of anticipated medical expenses.
- A list of other household expenses including amounts paid on a monthly basis.
- A list of other assistance the household is receiving including Low Income Home Energy Assistance (LIHEA), food stamps (SNAP), special assistance programs for medical expenses, etc.

***It is the responsibility of the participant to demonstrate that the use of the simplified medical deduction schedule creates a hardship.***

Please use the attached form to provide the necessary information for the Medical Hardship Committee to make a decision. Additional information that can assist the committee in reaching their decision can also be provided. However, failure to provide all necessary information will result in the committee denying the request.

### **RHA Simplified Medical Deduction Hardship Policy:**

Under RHA's Moving to Work (MTW) designation, a simplified medical deduction schedule was implemented for all annual recertifications beginning 1/1/2016. For participants wishing to have their portion of rent calculated using HUD's current rule of unreimbursed medical expenses rather than RHA's simplified medical deduction schedule, a Hardship Policy was also adopted. RHA has established a three person committee to review all requests for hardship. In order to be considered for a hardship and referred to the Medical Hardship Committee, participants must meet the following criteria:

- Household's monthly rent is no less than RHA's established minimum rent.
- Third party documentation must be provided detailing all anticipated medical expenses including monetary amounts and frequency.



**SIMPLIFIED MEDICAL DEDUCTION HARDSHIP REQUEST FORM**

Client Name: \_\_\_\_\_ Client Number: \_\_\_\_\_ Date: \_\_\_\_\_  
Client Address: \_\_\_\_\_

1. Please describe, in as much detail as possible, how the use of the simplified medical deduction schedule has created a hardship for you and/or your household (if additional space is needed, attach a separate page):

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

2. Please provide a list of all unreimbursed medical expenses anticipated in the upcoming year (if additional space is needed, attach a separate page):

<i>Example:</i>	<b>Description of Expense</b>	<b>Source</b>	<b>Amount</b>	<b>Frequency</b>
	Medicare Premium	Social Security	\$104.90	every month
	Prescription co-pays	Wal-Mart	\$74.50	every year
	Co-pay	Dr. Smith (PCP)	\$20.00	every 3 mo.
	Co-pay	Dr. Jones (Cardiologist)	\$40.00	every 6 mo.

<b>Description of Expense</b>	<b>Source</b>	<b>Amount</b>	<b>Frequency</b>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

*For the expenses listed above to be considered, documentation must be provided.*

3. Your current monthly expenditures (do not provide copies of these expenses):

Rent: _____	Auto Payment: _____	Transportation: _____
Electric/Gas: _____	Cable: _____	Other: _____
Phone: _____	Credit Cards: _____	Other: _____
Auto Insurance: _____	Loans: _____	Other: _____

4. Other assistance the household is receiving:

Low Income Home Energy Assistance (LIHEA):	No _____	Yes _____	Amount: _____
Food stamps (SNAP):	No _____	Yes _____	Amount: _____
Other (Patient Assistance Program from hospital):	No _____	Yes _____	Amount: _____