Executive Director
Hilary Lopez, PhD.

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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.

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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):**

Example:	Description of Expense	Source	Amount	Frequency
	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.

Description of Expense	Source	Amount	Frequency

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: _____