Case Name:
Case Number:
Date:
Specialist:
Phone:
Fax:
Email:

STATE OF MICHIGAN
Department of Human Services

If you do not understand this, call a DHS office in your area.
DHS employees are prohibited by law from providing legal advice.
Si ústed no entiende esto, llame a una oficina de DHS en su área.
La ley prohíbe a los empleados de DHS proporcionar asesoría legal.
إذا واجهت صعوبة في فهم هذا الطلب، فأتصل بمكتب DHS الموجود في منطقتك.
يحرّم القانون على موظفي DHS إعطاء النصيحة القانونية.

ENTER ADDRESSEE NAME
ENTER ADDRESSEE CARE OF
ENTER ADDRESSEE PO BOX OR STREET
ENTER ADDRESSEE CITY/STATE/ZIP

DEDUCTIBLE REPORT

EACH TIME A MEDICAL EXPENSE IS INCURRED BY A MEMBER OF YOUR FAMILY, COMPLETE ONE LINE OF THIS FORM. GIVE ALL REQUESTED INFORMATION. KEEP COPIES OF BILLS OR RECEIPTS FOR ALL MEDICAL EXPENSES, WE NEED TO SEE THEM.

DATE OF SERVICE	NAME OF FAMILY MEMBER	CHECK ONE	PROVIDER NAME AND ADDRESS	AMOUNT OF CHARGE	TOTAL AMT TO DATE
		☐ Doctor Visit ☐ Prescription ☐ Other			
		☐ Doctor Visit ☐ Prescription ☐ Other			
		☐ Doctor Visit ☐ Prescription ☐ Other			
		☐ Doctor Visit ☐ Prescription ☐ Other			
		☐ Doctor Visit ☐ Prescription ☐ Other			
		☐ Doctor Visit ☐ Prescription ☐ Other			
		☐ Doctor Visit ☐ Prescription ☐ Other			
		☐ Doctor Visit ☐ Prescription ☐ Other			
		☐ Doctor Visit ☐ Prescription ☐ Other			
		☐ Doctor Visit ☐ Prescription ☐ Other			
		☐ Doctor Visit ☐ Prescription ☐ Other			

When the expenses listed above are more than your deductible amount, return this form to your specialist immediately. **You may bring this form and proof of your medical expenses and income to the office or mail them in. COMPLETE, SIGN AND DATE PAGE 2 OF THIS FORM BEFORE YOU RETURN IT.**

1. List yourself and the name of each family member who lives with you.

Case Name	Case Number	Specialist

2. Does any family member receive any income from employment or self-employment? ☐ Yes ☐ No If yes, complete the following:	Total Monthly Earnings Before Deductions	Total Monthly Child Care for Employment Purposes
Person Working		
	$	$
Person Working		
	$	$

3. Does any family member pay support or guardianship expenses? ☐ Yes ☐ No If yes, complete the following:	Total Monthly Support Paid	Total Monthly Guardianship Expenses Paid
Person Paying Support/Guardianship Exp		
	$	$
Person Paying Support/Guardianship Exp		
	$	$

4. Other income you have. Include income of all family members. Every item must be completed

TYPE OF INCOME		MONTHLY AMOUNT	WHOSE INCOME
Social Security Benefits (RSDI)	☐ Yes ☐ No	$	
Supplemental Security Income (SSI)	☐ Yes ☐ No	$	
Retirement or Pension Benefits	☐ Yes ☐ No	$	
Veterans Benefits	☐ Yes ☐ No	$	
Disability Benefits	☐ Yes ☐ No	$	
Rental Income	☐ Yes ☐ No	$	
Workers Compensation	☐ Yes ☐ No	$	
Child Support or Alimony	☐ Yes ☐ No	$	
Unemployment Compensation	☐ Yes ☐ No	$	
Military Allotments	☐ Yes ☐ No	$	
Gambling Distributions (Casino profit sharing)	☐ Yes ☐ No	$	
Other	☐ Yes ☐ No	$	

5. Assets you have. Include assets of all family members. Every item must be completed

TYPE OF ASSET		VALUE OF ASSET	OWNER OF ASSET
Cash on hand, in a safety deposit box or patient trust fund	☐ Yes ☐ No	$	
Savings, Checking or Credit Union Accounts	☐ Yes ☐ No	$	
Home, life estate, life lease	☐ Yes ☐ No	$	
Real Estate (not your home)	☐ Yes ☐ No	$	
Mortgage, land contract or other notes payable to household member	☐ Yes ☐ No	$	
Savings bonds or money market funds	☐ Yes ☐ No	$	
Stock or mutual funds	☐ Yes ☐ No	$	
IRA, KEOGH, 401K or deferred compensation accounts	☐ Yes ☐ No	$	
Trust Fund(s)	☐ Yes ☐ No	$	
Life Insurance	☐ Yes ☐ No	$	
Annuity	☐ Yes ☐ No	$	
Cars, trucks, boats, motorcycles, other vehicles	☐ Yes ☐ No	$	
Tools & Equipment, Livestock or Crops	☐ Yes ☐ No	$	
Funeral contracts	☐ Yes ☐ No	$	
Burial plot(s), casket, etc.	☐ Yes ☐ No	$	
Certificates of Deposit (C.D.) or savings certificates	☐ Yes ☐ No	$	
Other	☐ Yes ☐ No	$	
Other	☐ Yes ☐ No	$	

I CERTIFY THAT TO THE BEST OF MY KNOWLEDGE, ALL ANSWERS ON THIS FORM ARE TRUE AND COMPLETE.

Signature	Date
Signature	Date

Department of Human Services (DHS) will not discriminate against any individual or group because of race, religion, age, national origin, color, height, weight, marital status, sex, sexual orientation, gender identity or expression, political beliefs or disability. If you need help with reading, writing, hearing, etc., under the Americans with Disabilities Act, you are invited to make your needs known to a DHS office in your area.