

February 5, 2021

CALIFORNIA DEPARTMENT OF SOCIAL SERVICES

EXECUTIVE SUMMARY

ALL COUNTY LETTER NO. 21-13

The purpose of this All County Letter is to introduce the United States Department of Agriculture, Food and Nutrition Service's *A Guide to the Treatment of Medical Expenses for Elderly or Disabled Household Members* along with state policy guidance on the CalFresh medical expense deduction. The Guide provides detailed information on eligibility, allowable expenses, and calculating the deduction.



KIM JOHNSON
DIRECTOR

STATE OF CALIFORNIA—HEALTH AND HUMAN SERVICES AGENCY
DEPARTMENT OF SOCIAL SERVICES
744 P Street • Sacramento, CA 95814 • www.cdss.ca.gov



GAVIN NEWSOM
GOVERNOR

February 5, 2021

ALL COUNTY LETTER (ACL) NO. 21-13

TO: ALL COUNTY WELFARE DIRECTORS
ALL CALFRESH PROGRAM SPECIALISTS
ALL CONSORTIA REPRESENTATIVES
ALL QUALITY CONTROL COORDINATORS

SUBJECT: CALFRESH MEDICAL EXPENSE DEDUCTION FOR ELDERLY
OR DISABLED HOUSEHOLD MEMBERS

REFERENCE: [UNITED STATES DEPARTMENT OF AGRICULTURE, FOOD
AND NUTRITION SERVICE \(USDA FNS\) A GUIDE TO THE
TREATMENT OF MEDICAL EXPENSES FOR ELDERLY OR
DISABLED HOUSEHOLD MEMBERS; TITLE 7 CODE OF
FEDERAL REGULATIONS \(CFR\) § 273.9\(c\)\(5\)\(i\)\(C\); 7 CFR §
273.9\(d\)\(3\)\(vii\); 7 CFR § 273.12\(c\)\(1\)\(i\); 28 CFR § 35.136\(f\); ALL
COUNTY LETTER \(ACL\) NO. 12-25; ACL NO. 17-35; ACL NO. 19-
89; MANUAL OF POLICIES AND PROCEDURES 63-502.331](#)

This letter introduces the United States Department of Agriculture, Food and Nutrition Service's (FNS) [A Guide to the Treatment of Medical Expenses for Elderly or Disabled Household Members](#) (hereafter referred to as "the Guide") and provides additional state policy guidance on the CalFresh medical expense deduction.

BACKGROUND

Individuals who meet the CalFresh definition of "elderly or disabled" are eligible to deduct qualifying medical expenses from their income to determine CalFresh eligibility.

California received approval from FNS to implement a Standard Medical Deduction (SMD) Demonstration Project beginning October 1, 2017, through September 30, 2021. Under the SMD Demonstration Project, households with at least one elderly or disabled member that verify qualifying medical expenses above \$35 per month may claim a standard deduction of \$120. Eligible households with qualifying medical expenses above \$155.01 per month may deduct actual expenses based on provided verification.

For additional guidance regarding the SMD, refer to [ACL No. 17-35](#) issued on April 25, 2017.

FNS GUIDE

The Guide provides detailed information on the medical expense deduction, including household member eligibility for the deduction, allowable medical expenses, and procedures for verifying medical expenses and calculating the deduction. It also serves as a useful reference tool for County Welfare Departments (CWDs) when questions arise regarding the medical deduction. Existing California Department of Social Services guidance regarding the medical expense deduction remains valid to the extent that it is not inconsistent with the Guide; if inconsistent, the Guide applies.

A copy of the Guide is provided as an attachment to this letter.

ADDITIONAL STATE GUIDANCE

This section of the letter provides additional state guidance on special circumstances not covered in the Guide. Refer below for guidance on benefit supplements, verification of medical expenses related to service animals, and transportation.

Timing of Acting on Medical Expense Changes

A household can report a medical expense at any time during the certification period. If the report of a new or changed medical expense results in an increase in benefits, the change must be effective no later than the first allotment issued 10 days after the date the change was reported ([7 CFR § 273.12\(c\)\(1\)\(i\)](#)). No supplement should be issued for previous month(s) or the month that the medical expense is reported when benefits are adjusted timely in response to the report of a new or changed medical expense.

This supersedes the guidance provided in [ACL No. 12-25](#) (page 34) and [ACL No. 17-35](#) (page 3) to align with federal regulations regarding timely action on reported medical expenses. Previous guidance instructed counties to issue a supplement for the current month the medical expense is reported: “if the [medical] expense is reported mid-period, the expense will be determined for the current and remaining months in the current SAR Payment Period.” Previous guidance is incorrect.

For example, a new medical expense reported and verified on April 15 would increase the household’s monthly benefit allotment for the May benefit month. No supplement is issued for April. If the same change were reported and verified on April 27, and the household’s normal issuance is on May 1, the household’s allotment must be increased

no later than the June benefit month. In this scenario, no supplement is issued for either April or May.

If the report of new or changed medical expense results in a decrease in benefits during the certification period, no action must be taken on the case. The reported change must be noted in the case file for review at the next periodic report (i.e., SAR 7) or recertification.

Service Animals

Service Animal Definition

For the purpose of CalFresh, service animals are animals that serve the needs of applicants and recipients who are older adults and/or disabled people. The costs of securing and maintaining a service animal are allowable medical expenses. According to the Guide, service animals must be “specially trained to assist the individual with the medical issue for which the animal is prescribed.” The Guide does not provide guidance specific to emotional support animals. However, if an emotional support animal meets both criteria outlined above, the emotional support animal must be treated as a service animal. As a result, the costs of securing and maintaining an emotional support animal that meets the definition of a service animal are allowable medical expenses.

Verification of a Service Animal's Status

[28 CFR § 35.136\(f\)](#) provides guidance on how public entities must determine whether an animal qualifies as a service animal. If it is evident that an animal is specially trained to perform a function that an older adult or disabled person cannot readily perform on their own, the CWD must consider this animal a service animal and allow the costs of securing and maintaining the service animal as medical expenses. A case comment noting the eligibility worker's observation is sufficient verification for this purpose. For example, if a dog is observed guiding an applicant who is blind or has low vision, a case comment noting the worker observed the use of the dog as a service animal is sufficient verification that the animal is a service animal.

If it is questionable whether an animal qualifies as a service animal, CWDs may only ask the recipient/applicant the following questions: (1) if the animal is required because of a disability, and (2) what tasks it is trained to perform. A case comment that states the animal is required because of a disability and lists the tasks the animal is trained to perform is sufficient verification when the status of a service animal is questionable. CWDs must not require formal documentation or proof of certification or licensing to verify that an animal is a service animal.

Medical Reimbursement for Service Animals

Direct payments to service animal owners intended to cover costs associated with a service animal must not be considered income for purposes of determining CalFresh eligibility and must be excluded from unearned income as a medical reimbursement in accordance with [7 CFR § 273.9\(c\)\(5\)\(i\)\(C\)](#). For example, payments such as the \$50.00 stipend from the Assistance Dog Special Allowance Program are not counted as unearned income when determining CalFresh eligibility. These payments must be considered, however, when determining the amount of medical expenses in accordance with [7 CFR § 273.9\(d\)\(3\)\(vii\)](#). The direct payment must be excluded from the individual's total medical expenses.

Transportation Costs: Mileage Reimbursement Rate

The Guide does not specify state-specific policy choices regarding the mileage reimbursement rate for transportation costs related to medical needs, such as travel to a doctor's appointment. The Guide highlights the state option to use either the federal or state mileage reimbursement rate.

The state policy set forth regarding transportation costs in [ACL No. 19-89](#) still applies. All CWDs must use the Internal Revenue System (IRS) standard business rate for the mileage rate. As of January 1, 2021, that rate is 56 cents per mile. CWDs must review the IRS standard business rate each year to ensure that the correct mileage rate is used. [Manual of Policies and Procedures 63-502.331](#) addresses state policy on the costs of public transportation vs. more costly modes of transportation.

If you have any questions or need additional guidance regarding the information in this letter, please contact the CalFresh Policy Section at CalFreshPolicy@dss.ca.gov.

Sincerely,

Original Document Signed By

ALEXIS FERNÁNDEZ, Chief
CalFresh and Nutrition Branch
Family Engagement and Empowerment Division

Attachment

Food and Nutrition Service

A Guide to the Treatment of Medical Expenses for Elderly or Disabled Household Members

Supplemental Nutrition Assistance Program
Certification Policy Branch

2019



Table of Contents

Introduction	1
State responsibilities and flexibilities.....	1
Determining who is elderly or disabled	3
Who is elderly or disabled?.....	3
Individuals who do not qualify.....	3
Timing of eligibility determination.....	3
How does an eligibility worker verify eligibility for the medical expenses deduction?	4
Determining whether a disability qualifies	4
Medicaid.....	4
Supplemental Security Income (SSI)	5
Federal Employee Compensation Act (FECA).....	5
How does elderly and disabled status affect household composition?	5
Nonhousehold members	6
Former or deceased household members.....	6
Effect of ineligible household members.....	6
Determining allowable medical expenses	8
What are eligibility workers allowed to question?.....	8
Special diets and over-the-counter medications.....	8
Schedule I controlled substances	9

Allowable expense decision tree.....	9
What are some examples of specific types of expenses?.....	9
Alternative therapies.....	9
Insurance policies	9
Payments on loans and credit card interest	10
Service animals	10
Transportation and lodging costs.....	11
Miscellaneous.....	11
How does an eligibility worker verify medical expenses?	12
Documentary Evidence.....	12
Collateral contacts and home visits	12
Missing verification	13
Are there any unique reporting and recertification requirements?	14
Calculating the Deduction.....	16
What is the amount of the excess medical expenses deduction?.....	16
When are billed medical expenses allowed to be deducted?	17
How are unpaid and past due medical expenses treated?	17
What is the Standard Medical Deduction?	17
How are medical expenses anticipated?	18
How are medical expenses averaged?.....	19
Fluctuating medical expenses	19
Expenses billed less often than monthly.....	19
One-time only expenses.....	19
Households certified for 24 months	19
How are reimbursements for medical expenses treated?	19
How are medical expenses deductions calculated for residents of group living arrangements?	20
How is the Medicaid spend-down treated?	20
How should case files be documented?	21

Answers to Knowledge Checks.....	23
Appendix	27
Supplemental Nutrition Assistance Program (SNAP) Excess Medical Expenses Deduction...	28
10 Facts about the Supplemental Nutrition Assistance Program (SNAP) Excess Medical Expenses Deduction.....	30

With thanks to Kathie Herrman (FNS Mountain Plains Regional Office), developer of the original Treatment of Medical Expenses Training Handbook, *Everything You Ever Wanted to Know About Medical Expenses, But Were Afraid to Ask*, January 1, 2000.

Introduction

The Food and Nutrition Service (FNS) is issuing this guide to clarify who is considered elderly and disabled for purposes of the Supplemental Nutrition Assistance Program (SNAP) and the requirements and dynamics of the excess medical expenses deduction. This guidance is based on relevant sections of the Food and Nutrition Act of 2008 (the Act), part 273 of title 7 of the Code of Federal Regulations (CFR) (SNAP regulations), and policy guidance issued by FNS.

Under SNAP regulations, households are entitled to a medical expenses deduction from their income calculation if one or more household members are elderly or disabled. Only those medical expenses incurred by the elderly or disabled household member in excess of \$35 per month and not paid by insurance or another third party can be deducted.

This guide examines how eligibility workers verify who qualifies as elderly or disabled for purposes of SNAP, determine allowable medical expenses, calculate the actual deduction, and act on reported changes. At the end of key sections, Knowledge Checks provide the opportunity to check the reader's understanding by answering questions based on the material covered. Answers are located near the end of the guide. The Appendix of this guide contains examples of informational materials written in plain language that can be used to help SNAP clients better understand the medical expenses deduction.

State responsibilities and flexibilities

State agencies are required to ensure that all eligible applicants receive the SNAP benefits to which they are entitled. The proper calculation of medical expenses deductions can be critical to determining correctly the amount of SNAP benefits that households containing elderly and disabled members are eligible to receive. State agencies must be sure that such households are aware of the deduction. State agencies should keep this in mind when designing applications and notices.

A State agency is not required to list every possible deductible expense on its SNAP application. A tiered approach may be more administratively feasible. For example, a household with an elderly or disabled member could receive a brief addendum that asks general questions about medical expenses. If the household reported owning a service animal, the State agency could then ask more detailed questions about food and medical care for the animal on an addendum or as part of the interview. If the household failed to report the costs of the service animal's food and medical care after being informed about deductibility of those items, the State agency would correctly conclude that the household does not want to deduct unreported veterinary

bills. SNAP regulations do not require that medical expense questions appear on a State agency's SNAP application, but eligibility workers need to cover the questions in the interview and document the questions and answers if they do not appear on the State's SNAP application.

Some State agencies include the following wording on SNAP applications: *"Failure to report or verify any of the above listed expenses will be seen as a statement by your household that you do not want to receive a deduction for the unreported expense."* State agencies that use this or similar application language are still required to ensure that applicants receive the SNAP benefits to which they are entitled. A household cannot be responsible for failing to report information, or for not verifying information, if the household is not aware of the requirement.

Many deductible medical expenses, such as transportation costs, are not readily apparent to clients. Therefore, a State agency using application language like that described above may only conclude that a household does not want to deduct an expense if:

1. the State agency asked about the unreported expense or requested verification through use of a question specific enough that a household completely unfamiliar with SNAP policy could answer the question;
2. the household did not report or verify the expense;
3. the State agency notified the household that verification is required, gave the household sufficient time to provide verification, and offered to help the household obtain verification; and
4. the State agency documented the reason for not deducting the expense.

Determining who is elderly or disabled

Who is elderly or disabled?

The first question an eligibility worker must answer is whether any household members are entitled to the medical expenses deduction. Households are entitled to a medical expenses deduction only if one or more members are elderly or disabled. SNAP regulations at 7 CFR 271.2 define who qualifies as “elderly or disabled” for purposes of SNAP.

Only households containing individuals who meet the SNAP definition of “elderly or disabled” are entitled to the excess medical expenses deduction. A person is considered disabled if they are certified for benefits listed in §271.2, even if they are not actually receiving benefits. This includes persons who have been certified but have not yet received their first payments, those who remain certified but whose benefits are entirely recouped to repay a prior overpayment, and those certified but not receiving payments due to income restrictions.

Individuals who do not qualify

The following individuals are **not** considered disabled for SNAP purposes unless they also meet one of the SNAP disability criteria under 7 CFR 271.2:

- An individual who is exempt from the student work requirement under §273.5 or work registration under §273.7 due to physical or mental unfitness for employment. For instance, a person may be exempt from these requirements due to a temporary illness or disability, but if they do not meet one of the §271.2 requirements they are not entitled to a medical expenses deduction.
- A spouse or other person receiving benefits as a dependent of an SSI or disability recipient.
- An individual who is disabled by Social Security standards but not receiving SSI benefits.
- An individual who has applied for SSI but has not been approved for SSI, presumptive disability payments, or emergency advance payments.

Timing of eligibility determination

If a household member will turn 60 years old during the first month of the certification period, the medical expenses deduction should be allowed beginning that month. If the person will turn 60 years old later in the certification period, any reported medical expenses should be

allowed beginning in the month the member turns 60. For individuals anticipating Social Security disability or SSI benefits, the deduction can be allowed when they begin receiving benefits.

How does an eligibility worker verify eligibility for the medical expenses deduction?

The second question an eligibility worker must answer is how to verify disability. This is described in SNAP regulations at 7 CFR 273.2(f)(1)(viii).

Determining whether a disability qualifies

In determining what is “a disability considered permanent under section 221(i) of the Social Security Act” under SNAP regulations, State agencies must obtain and use updated lists of what are considered permanent disabilities by the Social Security Administration (SSA). Eligibility workers may also determine by observation that an individual is unable to purchase and prepare meals because he or she suffers from a severe physical or mental disability even if the disability is not specifically mentioned on the SSA list.

If a disability is not on the SSA list and is not obvious to the eligibility worker, the eligibility worker must verify disability using a statement from a physician or licensed mental health practitioner certifying that the individual (in the physician's/practitioner's opinion) is unable to purchase and prepare meals because he or she suffers from one of the nonobvious disabilities mentioned in the SSA list, or is unable to purchase meals because he or she suffers from some other severe, permanent physical or mental disease or nondisease-related disability. State agencies may not require personnel responsible for making Social Security disability determinations to make a disability determination for SNAP purposes.

For a recipient of State disability payments to be considered disabled under SNAP, the State disability retirement system must have used criteria for determining the individual's disability status that can be reasonably seen to be the same as the SSA criteria. Similarly, in the case of individuals receiving State disability or blindness payments, the State agency must determine whether its payments to a particular individual are based on the Supplemental Security Income (SSI) rules. The State is in the best position to interpret its own laws as to whether a particular disability retirement benefit program in the State is “from a governmental agency”.

Medicaid

Receipt of Medicaid alone does not establish disability for SNAP purposes. Additionally, an individual subject to the Medicaid spend-down is not even considered a recipient of Medicaid until the spend-down requirement has been satisfied. For more information about calculating medical expenses under the Medicaid spend-down program, see [How is the Medicaid spend-](#)

down treated?

Supplemental Security Income (SSI)

A household member is considered to be disabled for SNAP purposes if they receive a regular SSI check, an SSI presumptive disability payment, or an SSI emergency advance payment.

- SSI presumptive disability payments are regular benefits paid for a temporary duration to people who will most likely meet SSI disability criteria. If a person is approved for presumptive SSI and then denied, the excess medical expenses deduction must be removed according to regular processing standards.
- An SSI emergency advance payment is a single payment provided to applicants who appear to meet the eligibility criteria and who are considered in need of immediate assistance.

Federal Employee Compensation Act (FECA)

Receipt of payments under the Federal Employee Compensation Act (FECA) is not, by itself, evidence of disability for SNAP purposes. There are two types of FECA payments:

1. Temporary benefits for employees injured on the job who receive benefits while they recover; these **do not** satisfy the SNAP disability requirements.
2. Benefits for permanently disabled employees who opt for FECA benefits in lieu of Civil Service Retirement (CSR) benefits; these **do** qualify as “disability retirement benefits from a government agency”.

How does elderly and disabled status affect household composition?

Under SNAP regulations, everyone who lives together and purchases and prepares meals together is considered a household. Some people who live together are required to be included in the same household, even if they purchase and prepare meals separately. This includes married spouses, children under age 22 who are living with their parents, and children under 18 years old who are living with and are under the parental control of a household member other than their parents.

Under §273.1(b)(2), an otherwise eligible member of a household may be considered, together with his or her spouse (if living there), a separate SNAP household from the others with whom the individual lives, if the individual is:

1. 60 years of age or older; and

2. Unable to purchase and prepare meals separately because of a disability considered permanent under the Social Security Act or a non-disease-related, severe, permanent disability.

To be eligible for separate household status because of disability, the elderly household member must be either receiving disability benefits or certified to receive the benefits at the time that the SNAP determination is made.

Separate household status may **not** be granted:

- When the income of the others with whom the elderly disabled individual lives (excluding the income of the elderly and disabled individual and his or her spouse) exceeds 165 percent of the poverty line; or
- To a spouse, any child under 18 years of age who is under the parental control of the elderly disabled person, or any person under 22 years of age who is the natural, adoptive, or step child of the elderly disabled person.

Nonhousehold members

A household that is responsible for paying the medical expenses of a nonhousehold member is not entitled to the medical expenses deduction because of that person.

Former or deceased household members

Under §273.9(d)(3)(ii), if an individual was a household member immediately prior to entering a hospital or nursing home, the household is entitled to the medical expenses deduction for those expenses incurred by the former household member if the household continues to be legally responsible for paying those expenses.

Medical expenses are also deductible if the elderly/disabled person who is in a home or hospital would have been included in the SNAP household prior to incurring the expense. The household does not have to be participating prior to incurring the expense to be eligible for the deduction, but the eligibility worker has to determine if the expenses were allowable or past due.

The medical expenses of a deceased household member (who met the definition of elderly or disabled while a member of the household) are allowable if the remaining household members are legally responsible for the bills.

Effect of ineligible household members

Under §273.11(c)(1)(i), if an elderly or disabled household member is ineligible because of a

disqualification for an intentional program violation, a felony drug conviction, fleeing felon status, noncompliance with a work requirement under §273.7, or imposition of a sanction while the member was participating in a household disqualified because of failure to comply with workfare requirements, the remaining eligible household members would continue to be eligible for the medical expenses deduction and the income and resources of the ineligible household member would also continue to count in their entirety.

Knowledge Check #1

1. A child is disabled by Social Security standards and receiving SSI benefits due to her disability. After the death of her father, she begins receiving Social Security death benefits based on her father's work history. Because the death benefits are higher, her SSI benefits are terminated. Is the child still eligible to receive a SNAP deduction for her medical expenses?
2. A 70-year-old woman was living with her 40-year-old daughter. They had separate SNAP households. The mother is admitted for long-term care in the hospital, so her case is closed. The daughter is making sporadic payments for hospital costs. May the daughter claim a medical expenses deduction for her mother's hospital expenses?
3. An elderly husband and wife were not participating in SNAP. The husband goes to the hospital in September. The wife applies for SNAP benefits in October. May the wife claim a medical expenses deduction for her husband's hospital expenses?
4. A household applies in January and is certified through December. One of the members will turn 60 in March and has allowable medical expenses. When should the expenses be deducted?

[Jump to answers.](#)

Determining allowable medical expenses

Once an eligibility worker has determined that the household contains elderly or disabled members, the next question is whether the household incurs allowable medical expenses. SNAP regulations at 7 CFR 273.9(d)(3) describe what are allowable medical expenses. Only medical expenses incurred by the elderly or disabled household member are allowable.

What are eligibility workers allowed to question?

SNAP regulations do not allow State agencies to evaluate whether a prescribed treatment is appropriate or necessary for an individual's medical condition. Additionally, the household's intent to pay is not a consideration in allowing an expense. The eligibility worker must instead evaluate whether a specific expense was prescribed or approved by a State-licensed practitioner or qualified health professional as determined by State definitions or authorities, and verify the expenses in accordance with SNAP regulations.

If it is questionable whether a practitioner is licensed, the local office can contact the State medical licensing board or the county medical association for assistance. A State agency may choose to list types of licensed and qualified practitioners in its certification manual. If the practitioner is licensed or qualified by the appropriate State authority, both the practitioner's fees and treatments and drugs prescribed or approved by the practitioner are deductible as medical expenses.

Special diets and over-the-counter medications

Special diets are not an allowable medical expenses deduction, even if they are prescribed or approved by a licensed practitioner or other qualified health professional recognized by the State. "Special diets" includes those prescribed for people with diabetes, prescribed liquid diets and nutritional supplements, allergy-free foods, special diets necessitated by religious considerations, and any item (including organic or fresh food and bottled water) that can be otherwise purchased with SNAP benefits. To determine whether a particular item is purchasable with SNAP benefits, State agencies should look to the product label. Items with a nutrition facts label that are sold in a SNAP-authorized retailer are eligible foods. Items with a supplement facts label are not eligible foods.

In making determinations about whether a particular over-the-counter medication is an allowable deduction or a non-allowable special diet, State agencies should apply a consistent policy and ensure that any allowable deduction is approved or prescribed by a licensed practitioner or other qualified health professional, not purchasable with SNAP benefits, and not part of a special diet as described above.

Schedule I controlled substances

Schedule I controlled substances are not allowable medical expenses under Federal law, regardless of whether they have been prescribed in accordance with State law. Under the Controlled Substances Act, marijuana is a Schedule I controlled substance that has no currently accepted medical use and cannot be prescribed for medicinal purposes. No Schedule I controlled substance may be allowed as a medical expenses deduction for purposes of SNAP.

Allowable expense decision tree

In considering whether an expense is allowable for the excess medical expenses deduction, ask the following questions:

1. Is the expense for a medication, medical supply, equipment, or service prescribed or approved by a State-licensed or qualified health practitioner?
If the answer is no, disallow the expense.
If yes, continue to the next question:
2. Is the expense for a special diet or an item that can be otherwise purchased with SNAP benefits?
If the answer is yes, disallow the expense.
If yes, continue to the next question:
3. Is the expense a Schedule I controlled substance?
If the answer is yes, disallow the expense.
If no, then generally the expense should be allowed.

What are some examples of specific types of expenses?

Alternative therapies

In some States, acupuncturists, massage therapists, herbalists, and other alternative medicine practitioners are licensed and recognized by the State Medical Board. If such a State-licensed health practitioner prescribes or approves an alternative therapy or medicine (such as acupuncture or herbs prescribed for therapeutic purposes), the costs for the practitioner and the therapy or medicine may be allowed as a medical expense if they cannot be otherwise purchased with SNAP benefits and are not prescribed as part of a special diet.

Insurance policies

Premiums for certain types of insurance policies are allowable deductions. Generally, if the insurance policy itself states that the payments are intended to cover medical expenses, it is reasonable to conclude that it is the household member's intent to use the benefits for paying

medical bills rather than to meet normal living expenses.

- Policies that pay a household a specific amount of money for each day the person is in the hospital are only allowable expenses if the policy itself states that the monies are intended to be used to cover medical expenses.
- Policies that state that the insurance payments are intended to cover cancer treatment or nursing home care are allowable expenses.
- Ambulance insurance policies are allowable expenses.

Only the portion of a medical insurance premium assigned to the elderly or disabled household member may be considered when calculating the deductible amount. If the policy does not specify how much of the premium is for each household member, the eligibility worker may prorate the premium amount among all household members. Only the prorated amount for the eligible member would be considered a deduction.

If the policy holder is not elderly or disabled, but the family policy includes a person who is eligible for the medical expenses deduction, that part of the premium for the eligible member may be used in calculating the deduction.

Payments on loans and credit card interest

Households may receive a medical expenses deduction for payments made on a conventional loan when the loan is used to pay a one-time only medical expense, but loan expenses (such as interest) are not allowable as part of the deduction. If a household obtains a mortgage for the purpose of financing a large medical expense, the mortgage payments should be treated as shelter costs and are not deductible as medical expenses.

Medical expenses billed on a credit card are allowable and considered billed when the charge account statement is received. The interest may not be included as a deduction.

Service animals

Costs of securing and maintaining any animal specially trained to serve the needs of elderly or disabled program participants are allowable medical expenses. Examples of such animals include seeing guide dogs, hearing guide dogs, and housekeeper monkeys. Food and veterinarian bills associated with the service animal are also allowable costs.

An animal must be specially trained to assist the SNAP recipient in order for its associated maintenance costs (such as veterinary bills, food, and other expenses) to be allowable deductions. While specific types of training, credentials, or certifications are not required, if

the animal has not been specially trained to assist the individual with the medical issue for which the animal is prescribed, it is not a service animal and its expenses are not deductible. A pet or companion animal that a client already owns does not automatically become a service animal if the client is later prescribed a service animal.

Transportation and lodging costs

Each State may set amounts to be considered reasonable costs of transportation and lodging that are incurred to obtain medical treatment or services. Use of State Department of Revenue or Federal Internal Revenue Service rates is permissible for mileage in a privately owned vehicle and should be applied consistently among all households in the State. State agencies should provide guidelines for eligibility workers to judge the reasonableness of lodging costs. State agencies have flexibility in developing these guidelines. The guidelines could be a flat, State-wide amount; could include variations for rural and urban areas; and could provide the basis for making exceptions to the established rates.

Eligibility workers must verify transportation and lodging costs submitted as medical expenses. Transportation costs include trips to a pharmacy or other location to fill prescriptions, fittings for dentures, hearing aids, or glasses, as well as trips to the doctor, dentist, etc. Like other medical expenses, only those transportation and lodging costs incurred by the elderly or disabled household member are allowable.

Miscellaneous

- The term “eye glasses” in the SNAP regulations also includes costs for contact lens.
- Postage for mail-order prescription drugs is an allowable medical expense.
- Adaptive equipment in vehicles and homes as well as monthly telephone fees for amplifiers and warning signals for elderly or disabled individuals, and the costs of telecommunications devices for the elderly or disabled may be considered allowable medical expenses deductions.
- A relative, who is not a household member, may be an attendant, as that term is used in §273.9(d)(3)(x). Child care expenses for a child receiving SSI are allowable medical costs if the expenses are necessary and identifiable. If a household incurs attendant care costs that could qualify under both the medical expenses deduction of §273.9(d)(3)(x) and the dependent care deduction of §273.9(d)(4), the costs may be deducted as a medical expense or a dependent care expense, but not both.

How does an eligibility worker verify medical expenses?

Although an eligibility worker may not question what a State-licensed or qualified health practitioner determines to be necessary medical treatment, verification is critical to ensure that claimed medical expenses are legitimate. Medical expenses totaling \$35 and less should not be verified since they will not result in a deduction.

Documentary Evidence

Per §273.2(f)(4), the eligibility worker must use documentary evidence as the primary source of verification. Documentary evidence consists of a written confirmation of the household's medical expenses. Examples of acceptable documentary evidence include:

- Bills or statements from providers of health insurance, services, and products.
- Health insurance policies that clearly describe the areas of coverage.

Acceptable verification shall not be limited to any single type of document and may be obtained through the household or other sources.

The household has primary responsibility for providing documentary evidence to support statements on the application and to resolve any questionable information. Households may supply documentary evidence in person, through the mail, through an electronic portal, or through an authorized representative; however, State agencies may not require households to present verification in person.

Eligibility workers must accept any reasonable documentary evidence provided by the household and must be primarily concerned with how adequately the verification proves the statements on the application.

Collateral contacts and home visits

Whenever documentary evidence cannot be obtained or is insufficient to make a firm determination of eligibility for the deduction or the amount of the deduction, the eligibility worker may require a collateral contact. Documentary evidence may be considered insufficient when the household presents bills that do not represent an accurate picture of the household's medical expenses (such as old bills).

A collateral contact is an oral confirmation of the household's expenses by a person outside of the household. The collateral contact may be made either in person or over the telephone. The eligibility worker may select a collateral contact if the household fails to designate one or designates one that is unacceptable to the eligibility worker. Examples of collateral contacts

for medical expenses include:

- Billing personnel in the doctor's office or the hospital.
- Insurance agents.
- Nursing home or home health care providers.
- Medical equipment rental agencies.

When information obtained from a source outside of the household contradicts statements made by the household, the eligibility worker must give the household the opportunity to resolve the discrepancy prior to using the information to determine benefits. State agencies must also ensure compliance with all Federal and State privacy and patient rights laws in obtaining information from collateral contacts. The eligibility worker should document in the case file any information obtained from collateral contacts as well as how any discrepancies are resolved.

Home visits may be used as verification on a case-by-case basis when documentary evidence is insufficient to make a firm determination of eligibility or benefit level, or cannot be obtained. Home visits must be scheduled in advance with the household.

Missing verification

If a household does not have needed verification at the interview, the State agency must notify the household, offer to assist the household in obtaining required verification, and give 10 days for the household to provide the particular items of missing verification. It is a best practice for the eligibility worker to document in the case file when such assistance is offered to the client. If the household does not provide verification within the 10 days provided, the eligibility worker must determine benefits without allowing a deduction for the unverified medical expense. If the verification is provided later, the eligibility worker will allow the expense in accordance with the procedures for acting on reported changes.

Households entitled to expedited service are entitled to a medical expenses deduction if they list medical expense amounts even if verification of those expenses are postponed. The verification must be provided prior to the second month's issuance, or until the third month of participation in the case of households that applied after the 15th of the month and were assigned a 2-month or longer certification period. If an amount of an allowable expense is not known at this time or cannot be reasonably anticipated based upon available information about the recipient's medical condition and public or private medical insurance coverage, the State agency shall consider the non-reimbursable portion of the medical expense only when the amount of the expense or reimbursement is reported and verified.

If a State agency determines that a household does not want to deduct an expense, the expense becomes non-deductible and is not included in any calculation of net income. If the household later reports or verifies the expense, the State agency would then deduct it.

Are there any unique reporting and recertification requirements?

A household's monthly medical expenses deduction for the certification period is based on the information reported and verified by the household, and any anticipated changes in the household's medical expenses that can be reasonably expected to occur during the certification period based on available information about the recipient's medical condition, public or private insurance coverage, and current verified medical expenses. Under §273.10(d)(4), a State agency shall not require households to file reports or to report changes about medical expenses during the certification period.

Under §273.12(c), during the certification period, the State agency shall not act on changes in the medical expenses of households eligible for the medical expenses deduction which it learns of from a source other than the household and which, in order to take action, require the State agency to contact the household for verification. The State agency shall only act on those changes in medical expenses that it learns about from a source other than the household if those changes are verified upon receipt and do not require contact with the household.

A household may voluntarily report changes in medical expenses during the certification period. If so, under §273.2(f)(8)(ii), the eligibility worker shall verify a change if it will increase the allotment but may not verify total medical expenses that are unchanged or have changed by \$25 or less, unless the information is incomplete, inaccurate, inconsistent, or outdated. The same restrictions on verification of previously unreported medical expenses and changes in total recurring medical expenses apply at recertification.

Under §273.10(d)(4), a State agency may either require verification prior to acting on the change, or require verification prior to the second normal monthly allotment after the change is reported. The State agency should specify in its State plan the option selected and apply the option consistently to all households. Regardless of which option is selected, in verifying a deductible expense, a State agency may not send the household a Request for Contact.

Under §273.12(c), if a household reports a change to an established deduction (other than a change in earnings or residence) during the first six months of the certification period that would affect the household's eligibility for, or amount of, the deduction, the State agency may choose to disregard the change and continue to provide the household the deduction amount that was established at certification until the household's next recertification or after the sixth month for households certified for 12 months. In the case of a household assigned a 24-month

certification period because all adult members are elderly or disabled, the State agency must act on any disregarded changes reported during the first 12 months of the certification period at the required 12-month contact. Changes reported during the second 12 months of the certification period can be disregarded until the household's next recertification.

If a State agency fails to allow a deduction for an allowable expense that was reported in time for the State agency to make the deduction in the appropriate month(s), the household is entitled to restored benefits.

Knowledge check #2

1. An elderly household member submits receipts for purchase of a walker, wheelchair rental, three sessions of hydrotherapy (with a letter signed by a State-licensed doctor stating that this is necessary to help with mobility), and three name-brand prescription medications. The eligibility worker is skeptical about the effectiveness of hydrotherapy and believes that generic medications would have been just as effective and cost a lot less. What should the eligibility worker do in this situation?
2. A disabled household member submits the following receipts as out-of-pocket medical expenses: purchase of gas to drive to another county to fill a prescription, purchase of nutritional shake mix and fresh fruit (with a letter signed by a State-licensed physician stating that these items are necessary for the household member to maintain a healthy weight), and purchase of medical marijuana (with a prescription signed by the same physician). Which, if any, of these are allowable medical expenses?
3. A household with an elderly member is being recertified in May. The elderly member reports a new prescription expense of \$10 a month. What information is the eligibility worker required to verify?
4. A household with a disabled member reports during the 8th month of a 12-month certification period a \$30 increase in a medical expense during the certification period. What is the eligibility worker required to do?

[Jump to answers.](#)

Calculating the Deduction

After the eligibility worker has identified all the medical expenses the household incurs and which of those expenses are allowable, the eligibility worker will need to anticipate when the household will receive bills for their expenses, and when those expenses may be averaged.

Households may elect to have fluctuating expenses averaged. If a recurring monthly expense does not fluctuate, it would not be averaged. It will be allowed each month as billed. One-time medical expenses may be deducted in a lump sum or averaged forward over the balance of the certification period. The eligibility worker must watch for expenses that will be paid by insurance or another third party as those expenses are not deductible. The eligibility worker must also determine if the expenses are current or past due.

A State agency may establish procedures to allow the method of budgeting a medical expense to be changed in the middle of a certification period, such as to allow a household to stop averaging an expense and have the remaining balance deducted at one time. However, the State agency must ensure that no action is taken which would cause a deduction to be allowed for an overdue expense or which would cause a double deduction.

What is the amount of the excess medical expenses deduction?

Only those medical expenses incurred by an elderly or disabled household member in excess of \$35 per month can be used as a deduction. The \$35 applies to the **total** expenses incurred by all elderly or disabled household members; it does not apply to each person's expenses if more than one person in the household is elderly or disabled.

- If an eligible household incurs medical expenses of \$100 a month, the eligibility worker would subtract \$35 from the \$100 and allow \$65 as the medical expenses deduction.
- If fluctuating expenses or a one-time expense has been averaged over the certification period, the \$35 is deducted from the monthly average each month.
- Per §273.10(e)(1)(ii)(B), in calculating net monthly income, a State agency may choose to include the cents associated with each individual medical cost in the computation of the medical expenses deduction and round the final medical expenses deduction amount.

When are billed medical expenses allowed to be deducted?

Except as described otherwise elsewhere in this section, a medical expense is only allowed in the month the expense is billed or otherwise becomes due, regardless of when or whether the household intends to pay the expense. “Or otherwise becomes due” may be interpreted to apply to situations in which a bill is received in one month, but the due date on the bill is in the following month. In these cases, the State agency may choose to allow the expense in either the month the bill is received or the month the expense is due. The option chosen by the State agency should be stated in its policy manual and applied in all cases.

Agreed-on monthly installments on one-time medical expenses are allowable in the month that each installment is due. Monthly installment arrangements do not need to be formal but should be verified if questionable. The expense is allowable even if the household was initially billed and an agreement plan set up before the certification period began.

Medical expenses billed on a charge account are considered billed when the statement is received. If the household does not pay off the balance by the first month due, subsequent monthly billings will be treated in the same manner as an installment plan. Amounts that are considered past due are never allowed and a particular expense may only be deducted once. The eligibility worker shall calculate a household’s expenses based on the expenses the household expects to be billed for during the certification period.

How are unpaid and past due medical expenses treated?

Under §273.10(d)(2), medical expenses carried forward from past billing periods are not deductible, even if they are included with the most recent billing and actually paid by the household. In any event, a particular expense may only be deducted once.

Each State agency should establish guidelines for how eligibility workers determine when a bill is considered past due. For instance, a State agency might establish that a bill is past due if it is unpaid 30 days after the billing date. The guidelines must be applied consistently across the caseload.

Unpaid medical bills may be taken into consideration when determining a household’s monthly medical expenses deduction for the certification period, provided that they are not past due.

What is the Standard Medical Deduction?

Standard Medical Deduction (SMD) demonstration projects allow State agencies to establish an assumed standard medical expense to replace actual costs of medical expenses for households in which an elderly or disabled member incurs medical expenses (excluding special

diets) in excess of \$35 a month.

The SMD makes it easier for seniors and disabled participants to qualify by decreasing their paperwork burden. Recipients of the SMD only have to provide verification that they have at least \$35.01 in allowable medical expenses rather than documenting every expense to maximize their deduction. The SMD also increases administrative efficiency for State agencies by decreasing the number of medical expenses that must be verified.

Generally, SMD demo projects adjust the amount of the heating/cooling standard utility allowance (HCSUA) to offset the cost of implementing this demo and maintain cost neutrality. Regional Offices should contact the Program Design Branch at FNS' National Office to ensure that they have the most up-to-date template and program requirements for State agencies to use when requesting to run an SMD demonstration project.

How are medical expenses anticipated?

An eligibility worker must calculate a household's medical expenses based on the expenses the household expects to be billed for during the certification period. Anticipation of the expenses must be based on the most recent month's bills, unless the household is reasonably certain a change will occur. The eligibility worker shall not automatically average past month's bills as a method of anticipating future expenses.

An eligibility worker should thoroughly explore with the household any changes from past expenses and any new expenses that can be reasonably expected to occur during the certification period based on available information about the recipient's medical condition, public or private insurance coverage, and current verified medical expenses. Once the eligibility worker has anticipated all expenses, those expenses may be allowed in the month they are expected to be billed or otherwise become due, or they can be averaged over the remainder of the certification period if they fluctuate (see below).

Under §273.10(d)(1)(i), any expense that is reported and can be reasonably anticipated based on available information about the recipient's medical condition and public or private medical insurance coverage, can be used to calculate the deduction. Therefore, if the household has met its deductible or the eligibility worker has verified that the household's insurance policy only pays 80 percent of all further expenses, the eligibility worker may anticipate that the insurance will pay 80 percent of the future expenses and allow 20 percent of those anticipated expenses as a deduction.

How are medical expenses averaged?

Fluctuating medical expenses

Fluctuating medical expenses may be allowed as deductions if regularly recurring, reasonably anticipated, and verified. Households may elect to have fluctuating expenses averaged or have them deducted in the months they are billed or otherwise become due. If a recurring monthly expense does not fluctuate, it would not be averaged. It will be allowed each month the expense is billed or otherwise becomes due. For instance, if a household incurs a \$50 a month expense for rental of medical equipment, the eligibility worker would simply allow the actual expense each month, rather than averaging the expense.

Expenses billed less often than monthly

Households may elect to have expenses that are billed less often than monthly averaged forward over the interval between scheduled billings. If a bill is averaged over the interval between billings, the expense can be allowed even if the bill was not received in the certification period. If there is no regularly scheduled billing interval, the expense may be averaged forward over the period the expense is intended to cover.

One-time only expenses

At certification, households may also elect to have one-time only expenses averaged forward over the entire certification period in which they are billed. Households reporting one-time only medical expenses during the certification period may elect to have a one-time deduction or to have the expense averaged over the remainder of the certification period. Averaging begins the month the reported change becomes effective. When a household elects to average a one-time medical expense, the household medical expense is averaged over the remaining months of the certification period, and \$35 is deducted from the average each month.

Households certified for 24 months

In the case of a household certified for 24 months that reports a one-time medical expense incurred during the first 12 months of the certification period, the State agency must give the household the option of deducting the expense for one month, averaging the expense over the remainder of the first 12 months of the certification period, or averaging the expense over the remaining months in the certification period. One-time expenses reported after the 12th month of the certification period will be deducted in one month or averaged over the remaining months in the certification period, at the household's option.

How are reimbursements for medical expenses treated?

Any medical expense that will be covered by a third-party reimbursement or an excluded vendor payment shall not be allowed as a deduction. In addition, an expense which will be

covered by an excluded vendor payment that has been converted to a direct cash payment under the approval of a federally authorized demonstration project shall not be deductible.

That portion of an allowable medical expense which is not reimbursable can be included as part of the household's medical expenses. If the household reports an allowable medical expense at the time of certification but cannot provide verification at that time, and if the amount of the expense cannot be reasonably anticipated based on available information about the recipient's medical condition and public or private medical insurance coverage, no deduction can be allowed until the reimbursable portion of the medical expenses is verified, no matter how long it takes to obtain proof of the reimbursement and the expense to the household. The household will have the nonreimbursable portion of the expense considered at the time the amount of the reimbursement is received or can otherwise be verified.

Note that this only applies to expenses subject to reimbursement. If the household has expenses that the eligibility worker is sure will **not** be reimbursed, the expenses may be allowed prior to verification.

How are medical expenses deductions calculated for residents of group living arrangements?

Group living arrangements (GLAs), described in section 3(m)(5)(B) of the Act, are public or nonprofit homes for individuals who are disabled or blind. Residents of GLAs are entitled to the medical expenses deduction for the medical costs they incur in excess of \$35 per month. In some cases, it may be challenging to determine a medical expenses deduction. The eligibility worker should first attempt to have the GLA separately identify allowable medical expenses. If the GLA can provide this information, this will be the amount used to calculate the deduction. If the amount paid for medical costs cannot be separately identified, no deduction is allowed for the costs.

Some GLAs may charge a basic rate for room and board and then have a higher rate depending on the amount of medical care a resident may need. In such instances, if a person is charged a higher rate, the basic rate minus the SNAP maximum allotment for a one-person household may be used to determine the shelter costs for that person, and the difference between the basic rate and the higher rate may be used to determine the medical expenses deduction.

These procedures apply to residents making their own payments and to those instances where a protective payee is handling the payments but is using the resident's own funds.

How is the Medicaid spend-down treated?

The Medicaid spend-down program is for people who are not income- or resource-eligible for Medicaid but who suffer from a catastrophic illness or otherwise require ongoing high medical

expenses. Once the household has a certain level of expenses compared to the household's available resources, the household can get some expenses paid under the spend-down program. There is no provision for restored benefits once the spend-down has been met unless the eligibility worker erred.

Each State has its own method of determining eligibility and calculating the amount of the Medicaid spend-down and the period it is intended to cover. Because of this, it is not possible to address every possible scenario specifically. The general rule is, however, that expenses less than the spend-down amount should be viewed as an out-of-pocket medical expense, like any other, and allowed for SNAP deduction purposes.

How should case files be documented?

Case files must be documented in sufficient detail so that a reviewer can determine the reasonableness and accuracy of the eligibility, ineligibility, benefit level, and other determinations. In documenting the excess medical expenses deduction, eligibility workers must thoroughly document all verification obtained and the time period covered by the medical expenses. Other examples of documentation include the following:

- The household members entitled to the medical expenses deduction and the verification obtained to prove that entitlement.
- The source of verification, which expenses are allowable, and which expenses are not allowable (i.e., if the expense is not an allowable expense or is past due, etc.).
- Treatment of reimbursements, when the verification for reimbursement was received, or verification that reimbursements are not applicable.
- The determination to average and the time periods over which the expenses have been averaged.
- Any non-cooperation by the household, or the non-receipt of any requested verification.
- The determination that information provided by the household appeared incomplete, inaccurate, inconsistent, or outdated. If verification received from someone outside of the household was inconsistent with the household's statements, document why the information was considered inconsistent and how the issue was resolved.
- If the household reports an expense but chooses not to have it included as a deduction, that fact should be documented.

- If a household needs to provide missing verification, document the date verification was requested and the type of verification needed. Document the date verification was received. If the household does not provide the verification, document that fact to support subsequent action.

Knowledge Check #3

1. An eligible household elects to average a one-time medical expense of \$300 over the next three months, which is the remainder of the certification period. How does the eligibility worker calculate the deduction?
2. A household consists of a husband and wife who are both over age 65. The husband incurs \$100 a month in expenses. The wife incurs \$55 a month. How does the eligibility worker calculate the deduction?
3. A household has recurring medical expenses for which the household is billed quarterly on January 1, April 1, etc. The household applies in February. How does the eligibility worker average the quarterly billing amount?
4. A household with an elderly member was certified from January through December. The elderly person was hospitalized in June, received a bill, and reported the expense in the middle of the certification period. How does the eligibility worker calculate the deduction?
5. An eligible household has total medical expenses of \$635 and third-party liability (health insurance). The household receives the bill for \$635 in February. In June, the insurance company pays \$400 of the bill. The household is then responsible for paying the remaining \$235. How should the eligibility worker calculate the deduction?

[Jump to answers.](#)

Answers to Knowledge Checks

Knowledge Check #1

1. A child is disabled by Social Security standards and receiving SSI benefits due to her disability. After the death of her father, she begins receiving Social Security death benefits based on her father's work history. Because the death benefits are higher, her SSI benefits are terminated. Is the child still eligible to receive a SNAP deduction for her medical expenses?

Answer: No, if the child's eligibility for the medical expenses deduction was based on receipt of SSI benefits and she does not meet any other criteria for a determination of disability under SNAP regulations.

2. A 70-year-old woman was living with her 40-year-old daughter. They had separate SNAP households. The mother is admitted for long-term care in the hospital, so her case is closed. The daughter is making sporadic payments for hospital costs. May the daughter claim a medical expenses deduction for her mother's hospital expenses?

Answer: No. The daughter is not allowed to claim a medical expenses deduction for her mother's costs because they were separate households before the costs were incurred.

3. An elderly husband and wife were not participating in SNAP. The husband goes to the hospital in September. The wife applies for SNAP benefits in October. May the wife claim a medical expenses deduction for her husband's hospital expenses?

Answer: Yes. The husband's expenses can be allowed because he would have been required to be a part of his wife's household.

4. A household applies in January and is certified through December. One of the members will turn 60 in March and has allowable medical expenses. When should the expenses be deducted?

Answer: No expenses would be allowed in January and February. The eligibility worker would determine medical expenses anticipated for March and subsequent months and compute benefits for March through the rest of the certification period based on those expenses.

Knowledge Check #2

1. An elderly household member submits receipts for purchase of a walker, wheelchair rental, three sessions of hydrotherapy (with a letter signed by a State-licensed doctor stating that this is necessary to help with mobility), and three name-brand prescription medications. The eligibility worker is skeptical about the effectiveness of hydrotherapy and believes that generic medications would have been just as effective and cost a lot less. What should the eligibility worker do in this situation?

Answer: Under §273.9(d)(3)(iii)(A), the costs of the walker and the wheelchair rental are allowable deductions. SNAP regulations do not allow the eligibility worker to evaluate whether a prescribed treatment is appropriate or necessary for an individual's medical condition; the eligibility worker must instead evaluate whether the hydrotherapy and prescription medications were prescribed or approved by a State-licensed practitioner or qualified health professional as determined by State definitions or authorities, and verify the expenses in accordance with SNAP regulations.

2. A disabled household member submits the following receipts as out-of-pocket medical expenses: purchase of gas to drive to another county to fill a prescription, purchase of nutritional shake mix and fresh fruit (with a letter signed by a State-licensed physician stating that these items are necessary for the household member to maintain a healthy weight), and purchase of medical marijuana (with a prescription signed by the same physician). Which, if any, of these are allowable medical expenses?

Answer: Under §273.9(d)(3), the reasonable costs of transportation to obtain medical treatment or services is deductible (including trips to a pharmacy or other location to fill prescriptions). The eligibility worker should calculate the deductible amount based on the mileage driven to the pharmacy and the transportation rate established by the State agency. The nutritional shake mix is not allowable because it is a nutritional supplement and therefore a special diet, and the fresh fruit is not allowable because it is an item that could otherwise be purchased with SNAP benefits. The medical marijuana is prohibited under §273.9(d)(3)(iii)(B).

3. A household with an elderly member is being recertified in May. The elderly member reports a new prescription expense of \$10 a month. What information is the eligibility worker required to verify?

Answer: Under §273.2(f)(8)(ii), an eligibility worker shall verify a change if it will increase the allotment but may not verify total medical expenses that are unchanged or have changed by \$25 or less, unless the information is incomplete, inaccurate, inconsistent, or outdated. Even though this change might increase the allotment, the

new expense is under \$25 so the eligibility worker is not required to verify it unless the information provided is incomplete, inaccurate, inconsistent, or outdated.

4. A household with a disabled member reports during the 8th month of a 12-month certification period a \$30 increase in a medical expense during the certification period. What is the eligibility worker required to do?

Answer: Under §273.2(f)(8)(ii), an eligibility worker shall verify a change if it will increase the allotment but may not verify total medical expenses that are unchanged or have changed by \$25 or less, unless the information is incomplete, inaccurate, inconsistent, or outdated. The eligibility worker is required to act on the change because it is a medical expense change reported by the household that would result in an increase in the household's benefit allotment. The eligibility worker must either require verification prior to acting on the change, or require verification prior to the second normal monthly allotment after the change is reported, depending on the option chosen by the State agency.

Knowledge Check #3

1. An eligible household elects to average a one-time medical expense of \$300 over the next three months, which is the remainder of the certification period. How does the eligibility worker calculate the deduction?

Answer: The eligibility worker would divide \$300 by 3 months to get \$100 per month and then would subtract \$35 each month, so the averaged expense would be \$65 for each of the next three months.

2. A household consists of a husband and wife who are both over age 65. The husband incurs \$100 a month in expenses. The wife incurs \$55 a month. How does the eligibility worker calculate the deduction?

Answer: The eligibility worker would add these expenses together to get \$155 and then subtract the \$35, leaving the household with a deduction of \$120 a month.

3. A household has recurring medical expenses for which the household is billed quarterly on January 1, April 1, etc. The household applies in February. How does the eligibility worker average the quarterly billing amount?

Answer: The eligibility worker would average the quarterly billing amount over the months of January, February, and March to determine the monthly average of medical expenses. The eligibility worker would apply this monthly average to the months of

February and March. This averaged amount would not be applied to January as the household was not participating in SNAP at that time.

4. A household with an elderly member was certified from January through December. The elderly person was hospitalized in June, received a bill, and reported the expense in the middle of the certification period. How does the eligibility worker calculate the deduction?

Answer: The household is reporting a one-time only medical expense during the certification period that will not be paid by a third party, such as insurance. The household may elect to have a one-time deduction of the full amount or have the entire expense averaged over the remaining months of the certification, since averaging begins the month the change would become effective.

5. An eligible household has total medical expenses of \$635 and third-party liability (health insurance). The household receives the bill for \$635 in February. In June, the insurance company pays \$400 of the bill. The household is then responsible for paying the remaining \$235. How should the eligibility worker calculate the deduction?

Answer: After verification of the reimbursed amount, the eligibility worker can allow a medical expenses deduction of \$200 ($\$235 - \35). This amount can be allowed in one lump sum of \$200 in the month it is verified or the \$235 expense can be averaged over the remainder of the certification period (minus \$35 each month).

Appendix

[SNAP Medical Expenses Client-Facing Handout](#)

[10 Facts about the SNAP Medical Expenses Deduction](#)

Supplemental Nutrition Assistance Program (SNAP) Excess Medical Expenses Deduction

Can I deduct medical expenses in SNAP?

If you are elderly or disabled, you may deduct (subtract) certain medical expenses from your SNAP income calculation. These expenses must be paid by you. You cannot deduct anything paid for by insurance or someone else. This deduction may help you get SNAP or get more SNAP benefits.

Am I elderly?

In SNAP, you are elderly if you are 60 years or older.

Am I disabled?

In SNAP, you are disabled if you meet **ONE** of the following criteria:

- You receive Federal disability or blindness payments under the Social Security Act, including Supplemental Security Income (SSI) or Social Security disability or blindness payments. **OR**
- You receive State disability or blindness payments based on SSI rules. **OR**

- You receive a disability retirement benefit from a governmental agency because of a permanent disability. **OR**
- You receive an annuity under the Railroad Retirement Act and are eligible for Medicare or are considered disabled under SSI. **OR**
- You are a veteran who is totally disabled, permanently homebound, or in need of regular aid and attendance. **OR**
- You are the surviving spouse or child of a veteran who is receiving VA benefits and is considered permanently disabled.

How much can I deduct?

Add together all of your monthly out-of-pocket medical expenses and subtract \$35. You may deduct whatever amount remains.

What kinds of medical expenses can I deduct?

You may deduct most medical expenses that are prescribed by a State-licensed or qualified health professional.

Examples of deductible medical expenses include:

- Doctor and dentist bills, including psychotherapy and rehabilitation.
- Prescription drugs and doctor-approved over-the-counter medication, including insulin.
- Dentures, hearing aids, eye glasses, and prosthetics.
- Medical equipment such as bandages, colostomy bags, insulin test strips, and walkers.
- Inpatient and outpatient hospital expenses, including nursing care.
- Reasonable costs of transportation and lodging to get medical treatment or services.
- Attendant care or home health aide costs.
- Health insurance premiums and Medicaid cost-sharing or spend down expenses.
- The costs of specially trained service animals, including maintenance costs.

Are there expenses I cannot deduct?

You may not deduct the costs of special diets, even if they are prescribed by a doctor. Examples of special diets are liquid diets, nutritional supplements, and any item that can be purchased with SNAP benefits, including prescribed foods.

How will my caseworker calculate my deduction?

Depending on your State, your caseworker will either apply a standard deduction from your income or calculate your deduction based on the medical expenses you anticipate being billed for during your certification period. Your caseworker will consider your most recent month's medical bills and discuss with you whether those expenses are likely to remain the same. Your caseworker will explain options you have in calculating medical expenses that repeat or vary monthly.

Will I have to provide proof of my expenses?

You must provide proof (verification) to support your SNAP application and to answer questions about your medical expenses or insurance payments. Your caseworker will give you a list of the types of verification you can provide.

What do I tell my caseworker at recertification?

When you recertify for benefits, tell your caseworker about any changes to your medical expenses. You do not have to file reports about medical expenses during your certification period.

Who can help me with my SNAP case?

For specific information about SNAP in your State or for questions about your SNAP case, please contact your local office. To find your local office, visit:

<https://www.fns.usda.gov/snap/state-directory>.

10 Facts about the Supplemental Nutrition Assistance Program (SNAP) Excess Medical Expenses Deduction

1. You must be elderly or disabled to be allowed to deduct (subtract) certain medical expenses from your SNAP income calculation.
2. You may only deduct the cost of medical expenses you pay out-of-pocket and that are more than \$35 a month when added together.
3. You may deduct most medical expenses that are prescribed by a State-licensed or qualified health professional.
4. You may deduct the reasonable costs of transportation and lodging to get medical treatment or services.
5. You may deduct the cost of health insurance premiums and Medicaid cost-sharing or spend down expenses.
6. You may not deduct the costs of special diets, even if they are prescribed by a doctor.
7. You may not deduct the cost of any item that can be purchased with SNAP benefits, including prescribed foods.
8. You must provide proof (verification) to support your SNAP application and to resolve any questions your caseworker has about your medical expenses or insurance payments.
9. You do not have to file reports about medical expenses during your certification period.
10. When you recertify for benefits, you must tell your caseworker about any changes to your medical expenses.

For specific information about SNAP in your State or for questions about your SNAP case, please contact your local office. To find your local office, visit:

<https://www.fns.usda.gov/snap/state-directory>.