Your Name: ______________________________Year of Expenses: __________

Medical Expense Worksheet

Deductible only if net cost exceeds 7.5% of Adjusted Gross Income (AGI)

Note: Do not include amounts paid for or reimbursed by insurance, or health insurance premiums paid with pre-tax income, or paid from an FSA or HSA

	Yes	No
Did you pay medical expenses for a person you cannot claim as a dependent..........		
Did your employer pay any part of your health Insurance..........		

Insurance (Only after-tax payments)

Hospitalization and Health Insurance Premiums (Include Medicare Supplemental Plans).......... $____________

Medicare Insurance Premiums Paid (Form SSA-1099).......... $____________

Long-Term Care insurance Premiums.......... $____________

Vision Insurance .... $____________

Dental Insurance.......... $____________

Long-Term Care Insurance Premiums.......... $____________

Doctor and Dentists

Dentists and Orthodontists.......... $____________

Hospitals, Nurses, Ambulance.......... $____________

Glasses, Contact Lenses, Eye Exams, Laser Eyes Surgery.......... $____________

Nursing or Long-Term Care Facility.......... $____________

Other

Medical Transportation (taxi, bus, ambulance, etc.).......... $____________

Parking Fees.......... $____________

Medical miles driven during the year to obtain medical care or supplies ....# of miles__________________

Lodging while obtaining medical treatment – *Limited to $50 per night, per person*.......... $____________

Home improvements made for medical purposes____$____________

Other____$____________

I certify that the above information is accurate and I have receipts to confirm proof of payments :

__________________________________ **Prepared by**

________________ **Date**

Susan E Thomas CPA, Ltd.

3960 Brown Park Dr. Suite C Hilliard, OH 43026

Phone: (614) 771-7700 Fax: (614) 771-7774 www.setcpa.com