Your Name:_____ Year of Expenses: _____

Medical Expense Worksheet

Deductible only if net cost exceeds 10% 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)

Health & Hospitalization Insurance Premiums (Include Medicare Supplemental Plans). $_____

Dental Insurance. $_____

Vision Insurance $_____

Long-Term Care insurance Premiums/Taxpayer. $_____

Long-Term Care insurance Premiums/Spouse $_____

Medicare Insurance Premiums Paid (Parts B, C & D from Form SSA-1099). $_____

Doctor and Dentists

Doctors, Hospitals, & Nurses $_____

Dentists & Orthodontists. $_____

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

Nursing or Long-Term Care Facility. $_____

Other

Prescriptions (RX) $_____

Medical Transportation (Taxi, Bus, Ambulance, Etc.). $_____

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 $_____

Parking Fees $_____

I certify that the above information is true and accurate, **and** I have receipts to confirm proof of payments.

_____ _____

Signature **Date**

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