Client 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 or reimbursed by your employer.*

| | 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 insurance premiums).

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) ***Taxpayer***..... $_____

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

**Doctor and Dentists**

Doctors, Hospitals, & Nurses ..... $_____

Dentists & Orthodontists ..... $_____

Glasses, Contact Lenses, Eye Exams, Laser Eye 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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