

**Be sure to have the following information available to
complete your application**

2013 INCOME

FEDERAL INCOME TAX RETURN (IF FILED – FORM 1040, 1040A, 1040 EZ,
OR TELEFILE WORKSHEET)

SOCIAL SECURITY (FORM SSA-1099)

PENSION AND ANNUITIES (FORM 1099-R)

INTEREST/DIVIDENDS (FORM 1099-INT, FORM 1099-DIV, FORM 1099-OID)

RAILROAD RETIREMENT (TIER I – RRB – 1099 & TIER II – RRB – 1099 - R)

IRA DISTRIBUTIONS (FORM 1099-R)

DEDUCTIBLE OUT-OF-POCKET MEDICAL EXPENSES

MEDICARE INSURANCE PREMIUMS

MEDICARE PRESCRIPTION DRUG PLAN PREMIUMS

SUPPLEMENTAL HEALTH INSURANCE PREMIUMS

CANCER INSURANCE POLICY PREMIUMS

NURSING HOME INSURANCE POLICY PREMIUMS

LONG TERM CARE INSURANCE PREMIUMS

PAYMENTS TO: DOCTORS, DENTISTS, OSTEOPATHS, NURSES, CHIROPRACTORS, AND OTHER
LICENSED MEDICAL PRACTITIONERS

PAYMENTS TO: HOSPITALS OR LICENSED NURSING CARE FACILITIES

PAYMENTS FOR: PURCHASES OF MEDICAL EQUIPMENT, CRUTCHES, HEARING
AIDS, EYEGASSES, CONTACT LENSES, DENTURES, ETC.

PRESCRIPTION DRUG COPAYMENTS (CALL YOUR PHARMACY FOR A TOTAL)

MILEAGE YOU TRAVEL FOR MEDICAL APPOINTMENTS

**Use the worksheet on the back of this page to help
calculate your out of pocket medical expenses.**

Out of Pocket Medical Expenses for Homestead Exemption

Listed below are just a few of the items that we can use for the medical expenses area of the application. Fill in the total yearly amount of out of pocket expenses next to the category that it pertains to. This is for informational purposes only...

THIS WILL NOT BE MAILED TO THE DEPARTMENT OF REVENUE

List following out of Pocket Medical Expenses you had in 2013

Prescriptions: \$ _____

(Contact your Pharmacy for totals)

Physician: \$ _____

Eye Doctor: \$ _____

Hearing Doctor: \$ _____

Dentist: \$ _____

Medicare: \$ _____

Medicare Part D: \$ _____

Supplemental Insurance: \$ _____

Chiropractor: \$ _____

Nursing Home Insurance: \$ _____

Cancer Insurance: \$ _____

Heart: \$ _____

Glasses/Contacts: \$ _____

Dentures: \$ _____

Hearing Aids: \$ _____

Hearing Aid Batteries: \$ _____

Canes: \$ _____

Crutches: \$ _____

Walkers: \$ _____

Wheelchairs: \$ _____

Insulin Syringes: \$ _____

In Home Licensed Care: \$ _____

Other: \$ _____

Approximate all mileage to the Medical Appointments and /or Hospital in 2013

Total Miles (January 1st through December 31st) _____ X 23.5 = \$ _____

List below any other medical expenses and the amounts that we have not listed above:

1. _____ Total Amount \$ _____

2. _____ Total Amount \$ _____

3. _____ Total Amount \$ _____

4. _____ Total Amount \$ _____

Total of above sections: \$ _____