PURCHASE ORDER REQUEST

**COMMUNITY ACTION COMMISSION OF FAYETTE COUNTY**

|  |  |
| --- | --- |
| **Vendor** | **Program Information** |
| Name: | Purchaser |
| Address: | Employee’s Name Date  Approved By: |
| City/State/Zip: | Supervisor’s Name Date  Project |
| VID: 2179 |  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **QUANTITY** | **DESCRIPTION** | **PRICE EACH** | **ELEMENT** | **TR #** |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |

**Explanation for Purchases:**

|  |
| --- |
|  |
|  |
|  |

Approved: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Executive or Deputy Director Date

Approved: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Fiscal Officer Date

**COMMUNITY ACTION COMMISSION OF FAYETTE COUNTY**

**1400 U.S. Route 22 NW**

**WASHINGTON COURT HOUSE, OHIO 43160**

**CHECK REQUEST**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  |  |  |  |  |
| Date: |  |  | Amount: |  |
|  | | |  | |
| To: | | |  | |
|  | | |  | |
|  | | |  | |
|  | | |  | |
| Purpose: | | | | |
|  | | | | |
|  | | | | |
|  | | | | |
|  | | | Requested By: | |
|  | | | | |
| Charge to Grant: | | | | |
| Element / Transaction # : | | | | |
| Approved for Payment: | | | | |

(Executive Director or Deputy Director Signature)



**Destination HOME – Medical Expense Allowance**

Medical expense allowances are allowed only for families where the head of household or spouse is disabled. A medical expense allowance is given for all expenses in excess of 3% of annual income. If a family is eligible for this allowance:

1. Count medical expenses of all household members
2. Include expenses that are not covered by Medicare, Medicaid, insurance or other sources and that are anticipated to be incurred during the 12 months following the family’s recertification, such as:

* Services of doctors and health care professionals
* Services of health care facilities
* Medical insurance premiums
* Prescriptions/non-prescription medicines
* Transportation to and from treatment
* Dental expenses
* Eyeglasses, hearing aids, batteries
* Payment for live-in attendant or periodic medical assistance
* Monthly payments or accumulated medical bills
* Medical care of a permanently confined family member if his/her income is included in annual income for rent purposes
* Expense for attendant care animals

**Medical expenses, which are not allowed, include:**

* Antiseptic diaper service
* Bottle/distilled water (unless verified medically necessary)
* Domestic help, care of a normal health baby by a nurse
* Funeral and burial expense
* Cemetery lots
* Life insurance policies
* Health club dues
* Maternity clothes
* Illegal operation or illegal treatment
* Social activities, such as dancing lessons or swimming lessons for the general improvement of health (even if recommended by a physician)
* Toothpaste, toiletries, cosmetics, etc.
* Trip for general improvement of health
* Vitamins for general health (unless verified medically necessary)
* Living expenses for live-in attendant
* Weight loss programs (even if recommended by a physician)
* Smoking cessation programs

***Verification***

The following are preferred forms of verification. If not possible to obtain these forms, other verification may be used.

1. Cost of treatment by physicians, dentists, and health care professionals must be verified by a health care professional.
2. Prescription/non-prescription costs:

* Physician must verify which medications are prescribed and the number of annual refills
* Cost of medications must be verified by receipts pharmacy printout, or by phone call to pharmacy (person conducting recertification must document in writing, the name and title of the person verifying information, the date, and the information provided).

1. Payment for non-routine expenses must be verified by health care provider, showing amount owed as of current date, agreed upon payment amounts and frequency.
2. Insurance premiums

* Copy of payment coupon or canceled check showing premium amount
* For Medicare premiums, Social Security award letter showing the Medicare deductions
* In all cases, a copy of the policy or other document showing coverage, deductibles, and percentage of expenses covered

1. Costs for attendant care must be verified by written certification from agency providing services as to the amount of payment received, hours of care provided, frequency of payments made. Attendant care must be medically necessary and verified by a health care professional.
2. Costs for attendant care animals:

* Statement of medical necessity by a health care provider
* Receipt for expenses such as food, grooming, etc.
* Written statement from veterinarian to verify expenses for anticipated medical care, such as shots, yearly physical, dental, etc.
* NOTE: Limit of one attendant care animal per handicapped person, unless additional animals are verified to be medically necessary in statement by a health care provider

**Calculation**

1. First calculate 3% of annual income (if 3% of annual income is less than the medical expense, an allowance can be given. If not, the family does not qualify for an allowance).
2. Next, subtract the 3% from the annual medium expense total. This is the actual allowance to be given.
3. Then subtract total expense deduction(s) from the annual income to determine adjusted income.

\*\* Medical expenses – 3% of annual income = medical expense allowance

\*\* Annual income – medical expense allowance & other eligible allowances = adjusted annual income

**Destination HOME Medical Deduction Worksheet**

*To determine if a participant is able to qualify for medical deductions, please refer to the “Medical Expense Allowance” guide.*

|  |  |
| --- | --- |
| Candidate Name: | |
|  | |
| $      Monthly Income x 12 (months) x .03 = $      \*\* this is 3% of annual income | |
|  | |
| Add all eligible medical expenses to determine grand total of medical expenses: $ | |
| Anticipated Expenses:   |  |  |  |  |  | | --- | --- | --- | --- | --- | | Type of Anticipated Expense | Total Amount Owed | Patient Amount | Number of Payments | Allowable Expenses | |  |  |  |  |  | |  |  |  |  |  | |  |  |  |  |  | |  |  |  |  |  | |  |  |  |  |  | |  |  |  |  |  | |  |  |  |  |  | | Subtotal: | | | | $ |   Routine Expenses Covered by Insurance:   |  |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | --- | | Type of Anticipated Expense | Total Anticipated Expenses | \* Deductible | Subtotal | X | Percent | = | Allowable Expenses | |  |  |  |  | X |  | = |  | |  |  |  |  | X |  | = |  | |  |  |  |  | X |  | = |  | | Deductible Subtotal | | | | | | $ | |   Insurance Premiums:   |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | | Insurance Company | Premium | X | Frequency Paid | = | Allowable Expenses | |  |  | X |  | = |  | |  |  | X |  | = |  | | Subtotal | | | | $ | | | |
|  | |
| $      (grand total medical) - $      (3% of annual income) = $      (allowable medical deduction) | |
| *\*\* Attach copies of all verification to this form.* | |
| Participant Signature: | Date: |
| Staff Signature: | Date: |



DESTINATION HOME

Community Action Commission of Fayette County

1400 U.S. Route 22 NW Washington Court House, Ohio 43160

740-335-7282 FAX 740-335-6802

**VERIFICATION OF MEDICAL EXPENSES**

**Destination HOME Tenant-based Rental Assistance Program**

Participant Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

SSN: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Agency: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Case Manager: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

HMIS No.: \_\_\_\_\_\_\_\_\_\_\_\_\_

**Specific purpose for requesting information:**The following participant named has applied for is re-certifying eligibility for housing assistance under a program of the U.S. Department of Housing and Urban Development (HUD). HUD requires the Community Action Commission of Fayette County and the Fayette County Metropolitan Housing Authority to verify all information that is used in determining the participant’s eligibility or level of be3nefits through a third party.

**Information participant is asking to be released:**

The participant has informed us that s/he has medical expenses that must be paid out of pocket. These expenses may include any of the categories listed on the attached form. Please provide us with information concerning the participant’s out of pocket medical expenses one year prior to that date of participant signature as indicated on the attached form. The participant has consented to the release of information as shown by the signed consent below.**PARTICIPANT RELEASE**

**RELEASE:** I hereby authorize the release of the requested information. Information obtained under this consent is limited to information that is no older than 36 months. There are circumstances, which would require the owner to verify information that is up to 5 years old, which would be authorized by me on a separate consent, attached to a copy of this consent.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Participant Signature Date

**PENALTIES FOR MISUSING THIS CONSENT:**

Title 18, Section 1001 of the U.S. Code states that a person is guilty of a felony for knowingly and willingly making false or fraudulent statements to any department of the United States Government. HUD, the PHA and any owner (or any employee of HUD, the PHA or the owner may be subject to penalties for unauthorized disclosures or improper uses of information collected based on the consent form. Use of the information collected based on this verification form is restricted to the purposes cited above. Any person, who knowingly or willfully requests, obtains or discloses any information under false pretenses concerning an applicant or participant may be subject to a misdemeanor and fined not more than $5000. Any applicant or participant affected by negligent disclosure of information may bring civil action for damages, and seek other relief, as may be appropriate, against the officer or employee of HUD, the PHA or the owner responsible for the unauthorized disclosure or improper use. Penalty provisions for misusing the social security number are contained in the Social Security Act at 42 U.S.C. 208(f) (g) and (h). Violation of these provisions are cited as violations of 42 U.S.C. 408(f) (g) and (h).

**VERIFICATION OF MEDICAL EXPENSES**

**Shelter-Plus Care Tenant-based Rental Assistance Program**

**INSTRUCTIONS TO COMPLETE FORM**We require an estimate of the participant’s anticipated medical expenses for the upcoming 12 months from the date of participant’s signature. You may base this estimate on the previous 12 months, expcluding any expenses from that period that you don’t expect to reoccur and adding new expenses you anticipate based on the particpant’s current condition. In the list below, check off the expenses included in your estimate.

We also require an estimate of the amount of these expenses that outside sources (e.g. health insurance) will reimburse. If the actual expenses and reimbursement differ from your estimates, the participant can contact us and we will make any appropriate rent adjustments.

ESTIMATED MEDICAL EXPENSES FOR THE UPCOMING 12 MONTHS: $\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Expenses included in this estimate (please check):

|  |  |
| --- | --- |
| Prescription Co-pay $ \_\_\_\_\_\_\_\_\_\_\_ each | Attendant care of periodic medical care |
| Services of physicians and other health care professionals | Transportation to and from treatment |
| Services of health care facilities | Spend-down $ \_\_\_\_\_\_\_\_  Paid $\_\_\_\_\_\_  \_\_\_\_ out of 12 months |
| Prescription/non-prescription medicines |
| Dental Expenses |
| Eyeglasses, contact lenses | Monthly payments on accumulated bills $ \_\_\_\_\_\_\_\_\_\_ |
| Hearing aids and batteries | Other medically necessary device, apparatus, or medication (specify general category) |
| Wheelchair, walker, and other supplies and equipment |

**ESTIMATED AMOUNT OF THESE MEDICAL EXPENSES REIMBURSED BY AN OUTSIDE SOURCE**(e.g. health insurance, Medicare, Medicaid): $\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |
| --- | --- |
|  |  |
| Name & title of person supplying information | Organization/Company |
| Telephone | Address |
| Signature | Date |

Tab 4 Assistance Tracking

|  |  |  |
| --- | --- | --- |
| Document | Date Completed | Initials of Staff Person |
| HMIS Intake/Referral Print Outs |  |  |
| Purchase Order |  |  |
| Check Request |  |  |
| W-9 |  |  |
| Checking/Savings/IRA/Tax Documents |  |  |
| Medical Expense Allowance |  |  |
| Medical Deduction Worksheet |  |  |
| Verification of Medical Expense |  |  |