MEDICAL EXPENSE WORKSHEET

DEPARTMENT OF HEALTH AND HUMAN SERVICES
SUPPLEMENTAL NUTRITION ASSISTANCE PROGRAM (SNAP)
SFN 187 (1-2023)

Clear Fields

Case Name	
Case Number	
Review Period	

ATTACH VERIFICATIONS TO THIS FORM

PROVIDER/ DESCRIPTION	AMOUNT BILLED	CALCULATION/NOTES	CHECK ONE			VERIFICATIONS CHECK ALL THAT APPLY			ALLOWABLE MONTHLY DEDUCTION
			ONE TIME	AVERAGE	MONTHLY	REQUESTED	RECEIVED	NOT RECEIVED	
			☐	☐	☐	☐	☐	☐	
			☐	☐	☐	☐	☐	☐	
			☐	☐	☐	☐	☐	☐	
			☐	☐	☐	☐	☐	☐	
			☐	☐	☐	☐	☐	☐	
									TOTAL

☐ The above are all of my expected medical expenses. I do not have any other medical expenses to claim.

☐ At this time, I have no medical expenses to claim. If I have medical expenses later, I may report and verify them I am not required, however, to report until my next review for Supplemental Nutrition Assistance Program (SNAP).

I understand that if I am unable to give proof of a medical expense, the expense will not be considered until I provide proof of it. I also understand that the portion of medical expenses paid by someone other than myself (Medicare, Medicaid, health insurance, etc.) cannot be used as a deduction.

☐ I understand that by checking this box and typing my name below, I am signing the Medical Expense Worksheet. I agree that my electronic signature is the legal equivalent of my handwritten signature.

Client Signature	Date

Return your signed and dated form to your local human service zone office
OR
Submit by mail to:
Department Of Health and Human Services
Customer Support Center
PO Box 5562
Bismarck ND, 58506
OR FAX: (701)-328-1006
OR Email: **applyforhelp@nd.gov**

For questions call Customer Support Center at: 1-866-614-6005
Human service zone office locations can be found here: https://www.hhs.nd.gov/human-service/zones