MEDICAL EXPENSE WORKSHEET

NORTH DAKOTA DEPARTMENT OF HUMAN SERVICES
SUPPLEMENTAL NUTRITION ASSISTANCE PROGRAM (SNAP)
SFN 187 (Rev. 05-2010)

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 as billed. 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.

Client Signature:	Date:

If help is needed in obtaining proof of your medical expenses, please contact your Eligibility Worker.

Eligibility Worker:	Date: