EQUAL HOUSING OPPORTUNITY

Income Deduction Checklist

Name:_____ Date:_____

Instructions: At initial certification and each annual reexamination, complete the questions about deductions from income expected in the coming 12 months.

Type of Deduction for Adjusted Income	Yes or No	Date Verified
1. Dependent Deduction		
a. Do you have any family members**, other than head, spouse, foster children, and live-in attendants** who are under age 18?	**Yes❑ No❑**	___/___/___.
b. 18 or older **and** either a full-time student or disabled?	**Yes❑ No❑**	___/___/___.
c. If yes, list names of such family members _____. _____. _____. _____.		
d. Verification source: Relationship of family members: _____. _____.		___/___/___.
e. Verification source: Full time student over age 18: _____. _____.		___/___/___.
f. Verification source: Disability of family member over age 18 _____. _____.		___/___/___.
2. Childcare Deduction		
a Is the family paying for care of children under age 13 so an adult can work?	**Yes❑ No❑**	___/___/___.
b. Is the family paying for the care of children under age 13 so an adult can attend education or job training classes?	**Yes❑ No❑**	___/___/___.
c. Is the family paying for the care of children under age 13 so an adult can look for work?	**Yes❑ No❑**	___/___/___.
d. If yes, list names of such family members _____. _____.		
e. Verification Source: Hours and cost of Child Care: _____. _____.		___/___/___.
3. Disability Expense Deduction		
a. Is the family paying for care or apparatus for a disabled family member so that an adult family member can work?	**Yes❑ No❑**	___/___/___.

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b. If yes, list name(s) of person with disability receiving care or using apparatus: _____. _____.		
c. Verification source: Disability of family member: _____. _____.		__/__/__.
d. Verification source: Need for care or apparatus _____. _____.		__/__/__.
e. Verification source: Cost of care or apparatus _____. _____.		__/__/__.
4. Elderly or Disabled Family Deduction		
a. Is the family head or spouse a person age 62 or older?	**Yes❑ No❑**	__/__/__.
b. Is the family head or spouse a person with a disability?	**Yes❑ No❑**	__/__/__.
c. Verification Source: Age of head or spouse _____. _____.		__/__/__.
d. Verification Source: Disability of head or spouse _____. _____.		__/__/__.
5. Unreimbursed Medical Expense Deduction (Elderly/Disabled families only)		
a. Is the family head or spouse elderly or disabled?	**Yes❑ No❑**	__/__/__.
b. If yes, does the family expect unreimbursed medical expenses over the period covered by the certification?	**Yes❑ No❑**	__/__/__.
c. List names of family members who expect unreimbursed medical expenses: _____. _____. _____. _____.		
Check type of unreimbursed medical expenses anticipated:		
Medical Insurance premiums (including Medicare)?	**Yes❑ No❑**	__/__/__.
Hospital costs?	**Yes❑ No❑**	__/__/__.
Doctor visits?	**Yes❑ No❑**	__/__/__.
Dentist visits?	**Yes❑ No❑**	__/__/__.
Dentist visits?	**Yes❑ No❑**	__/__/__.
Dentures, bridgework, crowns?	**Yes❑ No❑**	__/__/__.
Eye doctor visits?	**Yes❑ No❑**	__/__/__.
Eyeglasses or contact lenses?	**Yes❑ No❑**	__/__/__.
Clinic visits?	**Yes❑ No❑**	__/__/__.

	Therapy of any type (include physical, emotional and psychiatric)?	**Yes❑ No❑**	/ / .
	Laboratory fees, X-rays, Diagnostic tests?	**Yes❑ No❑**	/ / .
	Blood or oxygen?	**Yes❑ No❑**	/ / .
	Prescription or non-prescription medicines?	**Yes❑ No❑**	/ / .
	Hearing aid, batteries?	**Yes❑ No❑**	/ / .
	In-home health care?	**Yes❑ No❑**	/ / .
	Medical transportation?	**Yes❑ No❑**	/ / .
	Medical apparatus (rented or purchased)?	**Yes❑ No❑**	/ / .
	Medical costs of permanently institutionalized family member[20]	**Yes❑ No❑**	/ / .
	Hospice care of a family member?	**Yes❑ No❑**	/ / .
	Assistive animal expenses?	**Yes❑ No❑**	/ / .
e.	Other unreimbursed medical expense not listed above? Describe: _____. _____.	**Yes❑ No❑**	/ / .
f.	Verification Source(s): Unreimbursed Medical Expenses _____.		/ / .
	_____.		/ / .
	_____.		/ / .
	_____.		/ / .
	_____.		/ / .
	_____.		/ / .
	_____.		/ / .
	_____.		
	_____.		
6.	**List and verify any optional deductions here:**		

Applicant / Resident Certification

I hereby certify that I have answered the questions on this checklist truthfully and that the deductions listed on the form represents all the income deductions available to my household.

_____ Head of Household Name

_____ Head of Household Signature

_____ Housing Authority Witness

[20] But only if member's income is included in Annual Income