Denton Housing Authority
INTERIM (CHANGE) FORM
Childcare, Medical, and Disability Allowance

Date: _____

Head of Household: _____

Head of Household Social Security Number: _____

Name of Spouse or Co-head: _____

Street Address: _____

City: _____State: _____Zip_____

Contact #_____

Work #_____

Please complete the information listed below.

CHILDCARE EXPENSES:

Do you pay childcare while a family member **attends school full time?** Yes_____ No_____, if **yes** please complete the chart below.

NAME OF CHILD	NAME AND ADDRESS OF CHILDCARE PROVIDER	PHONE #	AMOUNT PAID PER WEEK
1.			
2.			

Do you pay childcare while a family member is **working or seeking employment?** Yes_____ No_____, if **yes** please complete the chart below.

NAME OF CHILD	NAME AND ADDRESS OF CHILDCARE PROVIDER	PHONE #	AMOUNT PAID PER WEEK
1.			
2.			

DISABILITY EXPENSES: Un-reimbursed expenses incurred to care for any member in the household with a disability, to the extent these expenses are necessary to enable a family member (including the member who is disabled) 18 years of age or older to be employed.

Do you pay attendant care for any member in your household with a disability? _____, if **yes,** what is the household member(s) name(s) _____ **how** much do you pay per month? $_____. Please provide the name and address of the individual or agency that provides the attendant care assistance. _____
_____

Do you pay for any auxiliary apparatus (wheelchairs, ramps, adaptations to vehicles, or other special equipment) for any member in your household with a disability? _____, if **yes**, what is the household member(s) name(s) _____**,** how much do you pay per month? $_____. Please list the equipment that is paid for_____
_____

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This Section applies **to Elderly (62 and older)** or to **persons with disabilities who are the Head of Household, Spouse, or Co-head**. If you qualify as one of these two categories you are able to claim medical expenses for every member of your household.

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MEDICAL EXPENSES: Medical expenses that are anticipated to be incurred during the 12 months following certification or reexamination which are not covered by an outside source such as insurance. The medical allowance is not intended to give a family an allowance equal to last year's expenses, but to anticipate regular ongoing and anticipated expenses during the coming year.

Medical expenses can include the following: Services of doctors and health care professionals, services of health care facilities, medical insurance premiums, prescriptions/non-prescription medicines(prescribed by a physician), transportation to treatment(cab fare, bus fare, mileage), dental expenses, eyeglasses, hearing aids (batteries), live-in or periodic medical assistance, monthly payment on accumulated medical bills, etc.

Are you or any member of your household receiving Medicare Benefits? Yes_____ No_____

Please list the name and address of all doctors, hospitals and clinics you are making medical payments to:

Name of doctor, hospital, or clinic: _____
Address: _____
Name of doctor, hospital, or clinic: _____
Address: _____
Name of doctor, hospital, or clinic: _____
Address: _____
Name of doctor, hospital, or clinic: _____
Address: _____

Please list the name and address of any pharmacies you are making payments to:

Name of Pharmacy: _____
Address: _____
Name of Pharmacy: _____
Address: _____
Name of Pharmacy: _____
Address: _____

Please list all additional medical deductions you may qualify for: Please include complete mailing addresses.

_____
_____
_____
_____
_____
_____
_____
_____

*** If you pay for over the counter medications or medical equipment please provide our office with a doctor's statement and receipt. If you pay out of pocket for additional health insurance, please provide our office with a copy of that information.**

If you have other changes in addition to childcare, disability expense, or medical please request additional change forms.

CONSENT FOR RELEASE OF INFORMATION

I, _____, do hereby authorize the Denton Housing
Print Name of Head of Household
Authority to contact any agencies, offices, groups or organizations to obtain any information or material that is deemed necessary to complete my application during the next twelve (12) months. I am also certifying that all information and material provided is true and complete to the best of my knowledge.

_____	_____
Signature of Head of Household	**Date**
_____	_____
Signature of Spouse or Co-head	**Date**
_____	_____
Signature of Other Adult 18 years and older	**Date**
_____	_____
Signature of Other Adult 18 years and older	**Date**
_____	_____
Signature of Other Adult 18 years and older	**Date**
_____	_____
Signature of Other Adult 18 years and older	**Date**

Denton Housing Authority
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