NORTH CAROLINA DIVISION OF AGING AND ADULT SERVICES
STATE/COUNTY SPECIAL ASSISTANCE

MEDICAL CARE SPECIAL
MEDICAL EXPENSE FORM

Special Assistance Recipient: _____

If you pay for any of the following items not covered by Medicaid or other insurance programs, show the monthly cost.

List prescribed medicines (over-the-counter) that are not covered by Medicaid, how often they are purchased, and the price per unit.
(For example, if you list two bottles of aspirin, give price per bottle).

MEDICINES	NUMBER OF TIMES PURCHASED EACH MONTH	COST PER PURCHASE	MEDICINES	NUMBER OF TIMES PURCHASED EACH MONTH	COST PER PURCHASE
1.			6.		
2.			7.		
3.			8.		
4.			9.		
5.			10.		

Please have above lists verified by your pharmacist.

(TO BE COMPLETED BY PHARMACIST)

Please review the above section completed by the applicant/recipient. These lists should include ONLY medicines and supplies prescribed by a doctor and not covered by Medicaid or other types of medical insurance. They are not to include co-payments.

If the items listed above, frequency of purchase, and costs are correct to the best of your knowledge please sign below.

_____ _____ _____
Signature of Pharmacist Name of Pharmacy Date

MEDICAL EXPENSE FORM- INSTRUCTIONS

Enter the information about medication not covered by Medicaid or other types of medical insurance. As indicated, the cost of co-payments is not to be included on this form. The list must be verified by the pharmacist who must sign and date and write in the name of the pharmacy at the bottom of the form.
If the SA recipient has a change in medical expenses after the application or review is approved, another Medical Expense Form can be completed at any time and forwarded to the SA case worker at the county Department of Social Services from which the recipient is receiving SA benefits. Any necessary adjustments will be made in the SA budget.