

**MONTANA BOARD OF HOUSING  
REVERSE ANNUITY MORTGAGE  
MEDICAL WORKSHEET**

Applicant Name: \_\_\_\_\_

Co-Applicant Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_, State: \_\_\_\_\_ Zip: \_\_\_\_\_

**Anticipated Gross Annual Family Income** - Complete Items As Applicable for subsequent 12-month period from date of application:

- |  |          |
|--|----------|
| 1. Wages, Salary, Interest, Dividends                                    | \$ _____ |
| 2. Attach Verification of Wages<br>(W-2, Pay Stub, Letter from Employer) | \$ _____ |
| 3. Supplemental Security Income (SSI)                                    | \$ _____ |
| 4. Social Security Disability Insurance (SSDI)                           | \$ _____ |
| 5. Social Security   | \$ _____ |
| 6. Pension, Retirement   | \$ _____ |

**Total Anticipated Annual Family Income**                      **A:**    \$ \_\_\_\_\_

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**Annual Allowed Non-Reimbursed, On-Going  
Medical Living Expenses To Exclude From Above:**

- 1. Hospital in-patient care, Rehabilitation Center,  
Nursing Home, Personal Care Facility \$ \_\_\_\_\_
- 2. Out-patient care including: Physical Therapy (PT),  
Occupational Therapy (OT), Speech therapy (ST),  
Out-patient surgery. \$ \_\_\_\_\_
- 3. Physicians, Physicians Assistants, Nurse Practitioners,  
Chiropractors \$ \_\_\_\_\_
- 4. Prescription Drugs/ Dietary Supplements./  
Other necessary over the counter medications. \$ \_\_\_\_\_
- 5. Consumable Medical Supplies \$ \_\_\_\_\_
- 6. Home Health Services including: PT, OT, ST,  
Nursing care, Hospice Service , Personal care assistance. \$ \_\_\_\_\_
- 7. Wellness and Health Maintenance Programs \$ \_\_\_\_\_
- 8. Health Insurance Premiums \$ \_\_\_\_\_
- 9. Other (must identify and explain) \$ \_\_\_\_\_

**Total Annual Allowed Expenses To Exclude From  
Total Gross Anticipated Annual Family Income. B:** \$ \_\_\_\_\_

**Total Gross Annual Family Income After Allowed  
Non - Reimbursed, On - Going Medical / Vocational /  
Independent Living Expenses (A - B) C:** \$ \_\_\_\_\_