

## BENEFIT ELIGIBILITY QUESTIONNAIRE

### A. INFORMATION ABOUT THE PERSON

|                    |               |                        |
|--------------------|---------------|------------------------|
| Full Name at Birth | Date of Birth | Social Security Number |
|--------------------|---------------|------------------------|

|  |   |
|--|---|
| Place of Birth (City, State and attach a copy of the person's birth certificate) | U.S. Veteran?<br><input type="checkbox"/> YES <input type="checkbox"/> NO |
|--|---|

|                |               |                                    |
|----------------|---------------|------------------------------------|
| Marital Status | Spouse's Name | Date and Place of Marriage/Divorce |
|----------------|---------------|------------------------------------|

U.S. Citizen  YES  NO  
 If NO, please attach proof of the person's A-number, the date of entry, and the port of entry. Please attach a copy of both sides of any employment authorization or permanent resident card or of any other documentation explaining the person's current immigration status.

Is there a **court appointed** legal guardian, alternate or standby guardian, conservator, or committee for the person?  
 YES  NO If YES, give the name and address (attach copies of the legal papers):

If the person is under age 21, do they live with their parents?  YES  NO

Does the person have Medicaid?  YES  NO

If YES: Client Identification Number (CIN): \_\_\_\_\_ Date approved: \_\_\_\_\_

If NO: Was a Medicaid application filed?  YES  NO If YES, complete the following:  
 Date of application: \_\_\_\_\_ Date of denial: \_\_\_\_\_  
 Reason for denial: \_\_\_\_\_

Is the person enrolled in the HCBS Waiver?  YES  NO Enrollment Date: \_\_\_\_\_

If NO: Has a HCBS Waiver application been filed for the person?  YES  NO  
 Date of application: \_\_\_\_\_ Date of denial: \_\_\_\_\_  
 Reason for denial: \_\_\_\_\_

What services is the person receiving/requesting? *Include all services provided by all agencies:*

### B. INFORMATION ABOUT THE PERSON'S INCOME

Does the person receive income from any source?  YES  NO  
 If YES, complete the following regarding all sources of income the person received during the last 3 months:

| Income Source                      | Who is Payee? | Claim Number | Monthly Amount |
|------------------------------------|---------------|--------------|----------------|
| SOCIAL SECURITY                    |               |              | \$             |
| SUPPLEMENTAL SECURITY INCOME (SSI) |               |              | \$             |
| Other Benefits                     |               |              | \$             |
|                                    |               |              | \$             |

Was the person ever employed or did they receive wages (including wages from a workshop)?  YES  NO  
 If YES, is the person currently employed?  YES  NO  
 If YES, complete the following about the current employer(s), other employers, and monthly gross wages during the last 3 months.

|             |         |             |
|-------------|---------|-------------|
| Employer(s) | Address | Gross Wages |
|-------------|---------|-------------|

**C. INFORMATION ABOUT THE PERSON'S ASSETS**

**Answer the following question only if the person will be residing in an ICF:**

Has the person sold, given away or transferred any cash, real estate, or other asset(s) during the last 60 months?

YES  NO

If YES, attach a sheet with details, including the type of asset, value, to whom the asset was sold/given/transferred, the date of the transaction and the amount for which the asset was sold.

Has the person placed any asset(s) into a trust or have any disbursements been made from a trust established for the person's benefit?

YES  NO

If YES, attach a copy of the trust document or a sheet with details about the trust, including the source of the money, the name of the trustee, location of the trust, account number and the value of the trust.

Does the person have any bank account(s), credit union account(s), certificates of deposit, annuity, 401(k), other retirement account, stocks, bonds, securities, or interest in real property?

YES  NO

If YES, attach copies (attach a sheet if needed for additional assets or details):

|   | Asset 1 | Asset 2 |
|---|---------|---------|
| Type of Asset   |         |         |
| Name of Person Receiving Bank Statements or Holding Records |         |         |
| Current Asset Value   |         |         |

Is there a burial fund for the person?  YES  NO If YES, attach a copy of the most recent statement.

Does the person have a pre-need funeral contract, a burial trust, a burial plot or other burial space items?

YES  NO If YES, provide details (attach a copy of the contract):

**D. FUTURE INCOME OR ASSETS FOR THE PERSON**

Does the person have an interest in, possible interest in, or expect to receive an inheritance, lawsuit settlement, trust fund or other asset?  YES  NO

If YES, describe the asset below (attach a sheet with details):

**E. INFORMATION ABOUT THE PERSON'S LIFE INSURANCE**

Is there Life Insurance on the person?  YES  NO If YES, complete the following (attach a copy of the policy):

Insurance Company Name and Address

Policy Number(s)

Face Value \$

Name and Address of the Person Holding the Policy

**F. INFORMATION ABOUT THE PERSON'S HEALTH INSURANCE**

| Does the person have Medicare?   | Effective Date | Claim Number |
|--|----------------|--------------|
| Part A Hospital Insurance <input type="checkbox"/> YES <input type="checkbox"/> NO     |                |              |
| Part B Medical Insurance <input type="checkbox"/> YES <input type="checkbox"/> NO      |                |              |
| Part D Prescription Drug Plan <input type="checkbox"/> YES <input type="checkbox"/> NO |                |              |
| Medicare Advantage Plan <input type="checkbox"/> YES <input type="checkbox"/> NO       |                |              |

Medicare Advantage Plan Name, Address and Phone Number

Is the person covered by other health insurance?  YES  NO If YES, please enclose a copy of the insurance certificate, policy, booklet or card (front and back) and complete the following:

Insurance Company Name and Address

|               |              |                     |
|---------------|--------------|---------------------|
| Policy Number | Group Number | Other Identifier(s) |
|---------------|--------------|---------------------|

|                            |                   |
|----------------------------|-------------------|
| Effective Date of Coverage | Subscriber's Name |
|----------------------------|-------------------|

Name and Address of Group/Employer

**G. IDENTIFYING INFORMATION ABOUT THE PERSON'S PARENTS AND SPOUSE**

|   | PARENT 1   | PARENT 2   | SPOUSE   |
|---|--|--|--|
| Full Name at Birth/Maiden Name          |  |  |  |
| Date of Birth                           |  |  |  |
| Place of Birth (City, State)            |  |  |  |
| Social Security Number                  |  |  |  |
| U. S. Citizen                           | <input type="checkbox"/> YES <input type="checkbox"/> NO | <input type="checkbox"/> YES <input type="checkbox"/> NO | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| U. S. Veteran<br>If YES, provide:       | <input type="checkbox"/> YES <input type="checkbox"/> NO | <input type="checkbox"/> YES <input type="checkbox"/> NO | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Serial Number                           |  |  |  |
| Claim Number                            |  |  |  |
| Receiving Disability/Retirement Benefit | <input type="checkbox"/> YES <input type="checkbox"/> NO | <input type="checkbox"/> YES <input type="checkbox"/> NO | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Date of Disability/Retirement           |  |  |  |
| Date and Place of Death, if applicable  |  |  |  |

**H. FINANCIAL REPRESENTATIVES FOR THE PERSON**

Is there any other person(s) who has financial information about the person?  YES  NO  
If YES, provide the information below (attach a sheet if needed):

| NAME | ADDRESS AND PHONE NUMBER | RELATIONSHIP |
|------|--------------------------|--------------|
|      |                          |              |
|      |                          |              |

**I. THE INFORMATION PROVIDED IS CORRECT TO THE BEST OF MY KNOWLEDGE**

|                                     |            |
|-------------------------------------|------------|
| Signature of Person Completing Form | Print Name |
|-------------------------------------|------------|

|                        |      |            |
|------------------------|------|------------|
| Relationship to person | Date | Home phone |
|------------------------|------|------------|

|            |            |       |
|------------|------------|-------|
| Cell phone | Work phone | Email |
|------------|------------|-------|