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? ☐ YES ☐ 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 ☐ YES ☐ NO

person? 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	☐ YES ☐ NO		
Part B Medical Insurance	☐ YES ☐ NO		
Part D Prescription Drug Plan	☐ YES ☐ NO		
Medicare Advantage Plan	☐ YES ☐ 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	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO
U. S. Veteran If YES, provide:	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO
Serial Number			
Claim Number			
Receiving Disability/Retirement Benefit	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ 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