BENEFIT ELIGIBILITY QUESTIONNAIRE

A. INFORMATION ABOUT THE INDIVIDUAL

Full Name at Birth	Date of Birth	Social Security Number

Place of Birth (City, State) (attach a copy of the individual'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 provide the individual's alien registration number, the date of entry, and the port of entry. Please attach a copy of both sides of the individual's Alien Registration Card or Permanent Resident Card and any other proof of lawful residence.

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

If the individual is under age 21, does he/she live with his/her parents? ☐ YES ☐ NO

Is the individual covered by 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 individual enrolled in the HCBS Waiver? ☐ YES ☐ NO Enrollment Date:_____

If NO: Has a HCBS Waiver application been filed for the individual? ☐ YES ☐ NO

Date of application: _____ Date of denial: _____

Reason for denial: _____

What services is the individual receiving? *Include **all services** provided by your agency and any other agency:*

B. INFORMATION ABOUT THE INDIVIDUAL'S INCOME

Does the individual receive income from any source? ☐ YES ☐ NO
If YES, complete the following regarding all sources of income the individual 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 individual ever employed or did he or she receive wages (including wages from a workshop)? ☐ YES ☐ NO
If YES, is the individual 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 INDIVIDUAL'S ASSETS

Answer the following question only if the individual will be residing in an ICF:
Has the individual 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 individual placed any asset(s) into a trust or have any disbursements been made from a trust established for the individual's benefit?
☐ YES ☐ NO
If YES, attach a photocopy 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 individual 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 an additional 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 individual? ☐ YES ☐ NO If YES, attach a sheet with details.

Does the individual 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 photocopy of the contract):

D. FUTURE INCOME OR ASSETS FOR THE INDIVIDUAL

Does the individual 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 INDIVIDUAL'S LIFE INSURANCE

Is there Life Insurance on the individual? ☐ YES ☐ NO If YES, complete the following:

Insurance Company Name and Address

Policy Number(s)	Face Value $

Name and Address of the Person Holding the Policy

F. INFORMATION ABOUT THE INDIVIDUAL'S HEALTH INSURANCE

Does the individual have Medicare? ☐ YES ☐ NO	**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 individual 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 INDIVIDUAL'S PARENTS and SPOUSE

	FATHER	MOTHER	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 INDIVIDUAL

Is there any other person(s) who has financial information about the individual? ☐ YES ☐ NO
If YES, provide the information below or attach a sheet with a detailed list:

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 Individual	Telephone	Date