

INSTRUCTIONS FOR COMPLETING THE BENEFIT ELIGIBILITY QUESTIONNAIRE

A. INFORMATION ABOUT THE INDIVIDUAL

Full Name at Birth: Enter the applicant's full name.

Date of Birth: Enter the applicant's date of birth. Please attach a photocopy of the individual's birth certificate.

Social Security Number: Enter the applicant's Social Security number.

Place of Birth: Enter the applicant's place of birth.

U.S. Veteran: Indicate whether the applicant is a U.S. Veteran by placing a check mark in front of either **YES** or **NO**.

Marital Status: Indicate the applicant's marital status by writing "Single", "Married", "Divorced", or "Widowed".

Spouse's Name: Write the name of the applicant's spouse, if applicable.

Date and Place of Marriage/Divorce: Indicate the city and state in which the applicant was married/divorced.

U.S. Citizen: If the applicant is a U.S. Citizen, place a check mark in front of **YES**; if the applicant is not a U.S. Citizen, place a check mark in front of **NO**. If No is checked, please provide an explanation of the applicant's status. If applicable, please provide the applicant's alien registration number, the date and port of entry, and 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? If yes, place a check mark in front of **YES**, write the name and address of the individual, and attach copies of the legal papers.

If under age 21, is the person living at home with his or her parents? If the applicant is under 21 years old and lives at home with his or her parents, place a check mark on the line in front of **YES**. Please provide proof of the applicant's residence such as a statement from a landlord, current rent receipt or lease, mortgage records, school records, current mail or a statement from another person.

If the applicant is under 21 years old, but does not live at home with his or her parents, place a check mark in front of **NO**.

If the applicant is 22 years old or older, do not answer this question.

Is the individual covered by Medicaid? If the applicant named currently has Medicaid, place a check mark in front of **YES**.

- **Client Identification Number (CIN):** The CIN is the same as the Medicaid Number – if the local Department of Social Services (DSS) or the New York City Human Resources Administration (HRA) assigned a Medicaid number to the person, enter the number. A Medicaid number consists of eight characters: two letters, followed by five numbers and then one letter, such as AB12345C. This number will appear on the person’s Medicaid card.
- **Date Approved:** Enter the date that the Medicaid application was approved by the local Department of Social Services (DSS) or the New York City Human Resources Administration (HRA).

If the applicant does not have Medicaid place a check mark on the line in front of **NO**.

Was a Medicaid application filed? If the applicant has had a Medicaid application filed, place a check mark on the line in front of **YES**.

- **Date of Application:** Enter the date that the Medicaid application was filed with the local Department of Social Services (DSS) or the New York City Human Resources Administration (HRA).
- **Date of Denial:** If the Medicaid application was denied, enter the date that the Medicaid application was denied by the local DSS/HRA
- **Reason for Denial:** Enter the reason that the local DSS/HRA provided when they denied the application. If a denial notice was received, please attach a copy of the notice to this form.

Is the individual enrolled in the Home and Community Based Waiver (HCBS) Waiver? If the applicant currently is enrolled in the HCBS Waiver, place a check mark in front of **YES**.

- **Enrollment Date:** Enter the date that the person named enrolled in the HCBS Waiver program through the local DDSO (Developmental Disabilities Services Office)/NYCRO (New York City Regional Office).

If the applicant is not currently enrolled in the HCBS Waiver, place a check mark in front of **NO**.

Has an HCBS Waiver application been filed? If an application for an HCBS Waiver was filed by any agency for the person, place a check mark in front of **YES**. Then provide the following information:

- **Date of Waiver application:** Enter the date that the HCBS Waiver application was filed with the local DDSO/SDIS.
- **Date of Denial:** If the HCBS Waiver application was denied by the local DDSO/NYCRO, enter the date that the application was denied.
- **Reason for Denial:** Enter the reason that the local DDSO/NYCRO provided when they denied the application. If a denial notice was received please attach a copy of the notice.

What services is the individual receiving? List all of the services the individual is receiving, whether by your agency or any other agency.

B. INFORMATION ABOUT THE INDIVIDUAL'S INCOME

Does the individual receive income from any source? If the applicant receives income, place a check mark in front of **YES**.

- **Income Source:** List sources of income such as Social Security Disability Insurance (SSDI), Supplemental Security Income (SSI) or Other Benefits (Railroad Retirement (RRB), Child Support or other benefits paid to a person that they do not perform work to receive).
- **Who is Payee?** A payee is the person who receives the funds. The applicant may be payee for their own benefits or a family member or other trusted adult may receive the funds.
- **Claim Number:** Enter the SSA/SSI or Other Claim Number associated with the benefit check.
- **Monthly Amount:** Enter the monthly benefit amount received.

Was the individual ever employed or did he or she receive wages (including wages from a workshop)? If the applicant has ever worked, place a check mark in front of **YES**.

- **If Yes, is the individual currently employed?** If so, place a check mark in front of **YES**.
- **If Yes, complete the following about the current employer(s), other employers, and monthly gross wages during the last 3 months:** List the employer, employer's address, and monthly gross wages during the last 3 months on the line provided. If more than one employer, attach a separate sheet.

If the applicant is not currently employed, place a check mark in front of **NO**.

C. INFORMATION ABOUT THE INDIVIDUAL'S ASSETS

Has the individual sold, given away or transferred any cash, real estate, or other asset(s) during the last 60 months? *This question is to be answered only if the applicant will be residing in an ICF; otherwise, skip to the next question.*

If the applicant has sold, given away or transferred any cash, real estate or other assets in the last 60 months, place a check mark in front of **YES**. Attach a sheet listing 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. If the applicant has not sold, given away or transferred any cash, real estate or other assets in the last 60 months place a check mark in front of **NO**.

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? If the applicant is the beneficiary of a trust or has placed any asset(s) into a trust, place a check mark in front of **YES**. Please attach a photocopy of the trust document or a sheet detailing the trust, including where the money came from, the name of the trustee, where the trust is located, the account number of the trust, and the value of the trust. If the applicant has not placed any asset(s) into a trust and is not the beneficiary of a trust, place a check mark in front of **NO**.

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? If so, place a check mark in front of **YES**. In the space provided, enter information about all asset(s) owned by the applicant.

- **Type of asset.** Enter the type of asset(s) owned by the applicant. Examples of an asset include savings and checking accounts at a bank or credit union, trust accounts, 401(k) accounts, stocks, bonds or certificates of deposit.
- **Name of Person Receiving Bank Statements or Holding Records.** Enter the name on the account.
- **Current Asset Value.** Enter the current value of each asset.

Is there a burial fund for the individual? If the applicant owns a burial fund, place a check mark in front of **YES** and attach a photocopy of the account information, or list the name and address of where the money is, account number and amount of the burial fund. If the applicant does not have a burial fund, place a check mark in front of **NO**.

Does the individual have a pre-need funeral contract, a burial trust, a burial plot or other burial space items? If the applicant has one or more of these items, place a check mark in front of **YES** and attach a photocopy of the pre-need contract, trust or plot. If that is not available, list the name and address of where the contract is held, account number and amount of the burial fund item(s). If the applicant does not have a burial fund, place a check mark in front of **NO**.

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? If the applicant is expected to be beneficiary of a trust or if the person will be receiving a large amount of money in the future, place a check mark in front of **YES**. Please attach a photocopy of any legal papers pertaining to this asset or a sheet detailing the situation. If the applicant is not expected to receive any future money, place a check mark in front of **NO**.

E. INFORMATION ABOUT THE INDIVIDUAL'S LIFE INSURANCE

Is there Life Insurance on the individual? If the person owns a life insurance policy, place a check mark in front of **YES**. Then:

- Enter the Insurance Company Name(s) and Address(es)
- Enter the policy number(s)
- Enter the Face Value of the policy (face value is the basic death benefit or maturity amount of the policy that is specified on its first page)
- Enter the name and address of the person holding the policy if the applicant is not the one holding the policy.

F. INFORMATION ABOUT THE INDIVIDUAL'S HEALTH INSURANCE

Does the individual have Medicare? If the applicant is covered by Medicare, place a check mark in front of **YES**.

Part A Hospital Insurance: If the applicant has Medicare Part A, place a check mark in front of **YES**.

- **Effective Date:** Enter the date that Medicare Part A started.
- **Claim Number:** Enter the Medicare number that shows on the Medicare Card.

Part B Medical Insurance: If the applicant has Medicare Part B, place a check mark in front of **YES**.

- **Effective Date:** Enter the date that Medicare Part B started.
- **Claim Number:** Enter the Medicare number that shows on the Medicare Card.

Part D Prescription Drug Plan: If the applicant has Medicare Part D, place a check mark in front of **YES**.

- **Effective Date:** Enter the date that Medicare Part D started.
- **Claim Number:** Enter the Medicare number that shows on the Medicare Prescription Card.

Medicare Advantage Plan: If the applicant is enrolled in a Medicare Advantage Plan, place a check mark in front of **YES**.

- **Effective Date:** Enter the date that Medicare Advantage Plan started.
- **Claim Number:** Enter the Medicare Advantage Plan number that shows on the insurance card.
- **Information about the Medicare Advantage Plan:** List the name, phone number and address of the Medicare Advantage Plan.

If the applicant is not covered by Medicare, place a check mark in front of **NO**.

Is the individual covered by other health insurance? If the applicant has health insurance coverage, place a check mark in front of **YES**.

- **Insurance Company Name and Address:** Enter the name of the applicant's health insurance company and the company's address.

- **Policy Number:** Enter the policy number that shows on the applicant's insurance card.
- **Group Number:** Enter the group number that shows on the applicant's insurance card.
- **Other Identifier(s):** Enter any other number that might be associated with the applicant's insurance.
- **Effective Date of Coverage:** Enter the date that the insurance coverage first started for the applicant.
- **Subscriber's Name:** Enter the name of the primary person who has the insurance.
- **Name and Address of Group/Employer:** If the health insurance coverage is through a group plan, list the name and address of the group or employer. If coverage is not through a group or employer, leave this space blank.

G. IDENTIFYING INFORMATION ABOUT THE INDIVIDUAL'S PARENTS AND SPOUSE

Full Name at Birth/Maiden Name: Enter the father's name, mother's maiden name, and spouse's name in the appropriate columns.

Date of Birth: Enter the date of birth of the father, mother, and spouse in the appropriate columns.

Place of Birth (City, State): Enter the city and state in which the father, mother, and spouse were born in the appropriate columns.

Social Security Number: Enter the father's, mother's, and spouse's social security numbers in the appropriate columns.

U.S. Citizen: If the father, mother, or spouse is a U.S. Citizen, place a check mark in front of **YES** in the appropriate column(s). If the father, mother, or spouse is not a U.S. Citizen, place a check mark in front of **NO** in the appropriate column(s).

U.S. Veteran: If the father, mother, or spouse is a U.S. Veteran, place a check mark in front of **YES** in the appropriate column(s).

- **Serial Number:** Enter the Veterans Association (VA) Serial Number for the father, mother, and/or spouse that is a U.S. Veteran.
- **Claim Number:** Enter the Claim Number for VA Benefits for the father, mother, and/or spouse that is a U.S. Veteran.

If the father, mother, or spouse is not a U.S. Veteran, place a check mark in front of **NO** in the appropriate column(s).

Receiving Disability/Retirement Benefit: If the father, mother, or spouse is receiving disability or retirement benefits, place a check mark in front of **YES** in the appropriate column(s). If the father, mother, or spouse is not receiving disability or retirement benefits, place a check mark in front of **NO** in the appropriate column(s).

Date of Disability/Retirement: If the father, mother, or spouse is disabled or retired, enter the date that the disability or retirement started in the appropriate column(s).

Date and Place of Death, if applicable: If the father, mother, or spouse is deceased, enter the date(s) of death in the appropriate column(s).

H. FINANCIAL REPRESENTATIVES FOR THE INDIVIDUAL

Is there any other person(s) who has financial information about the individual?

If an individual is known to have financial information about the applicant for benefits, place a check mark in front of **YES**. Enter the individual's name, address and relationship to the applicant for each person who has financial information about the applicant. If there is no other person known to have financial information regarding the applicant, place a check mark before the **NO**.

The information provided is correct to the best of my knowledge. The person completing the financial investigative form should sign the form, print their name, indicate their relationship to the applicant, and provide their telephone number and the date the form was completed.