

BENEFITS ELIGIBILITY FORM

Name:

Address:

Phone:

City/State/Zip Code:

DOB/Age	Ethnicity	Marital status	Monthly Income (including Spouse)	Health Status
DOB	<input type="checkbox"/> American Indian or Alaskan Native	<input type="checkbox"/> Single	<input type="checkbox"/> Less than \$1,000	<input type="checkbox"/> Excellent
<input type="checkbox"/> Age 18-49	<input type="checkbox"/> Asian or Asian American	<input type="checkbox"/> Married	<input type="checkbox"/> Between \$1,000-1,499	<input type="checkbox"/> Very good
<input type="checkbox"/> Age 50-59	<input type="checkbox"/> Black or African American	<input type="checkbox"/> Married-Living Single	<input type="checkbox"/> Between \$1,500-1,999	<input type="checkbox"/> Good
<input type="checkbox"/> Age 60-64	<input type="checkbox"/> Hispanic, Latino, or Spanish origin	<input type="checkbox"/> Divorced	<input type="checkbox"/> Between \$2,000-3,000	<input type="checkbox"/> Fair
<input type="checkbox"/> Age 65-74	<input type="checkbox"/> Native Hawaiian or Pacific Islander	<input type="checkbox"/> Widowed	<input type="checkbox"/> More than \$3,000	<input type="checkbox"/> Poor
<input type="checkbox"/> Age 75+	<input type="checkbox"/> White			

Monthly Medical Expense Not Covered by Insurance \$

What do you want to learn more about? Check all that apply.

- Medication Benefits
 Health Care
 Income Assistance
 Food & Nutrition
 Housing & Utilities
 Tax Relief
 Veterans
 Employment
 Transportation
 Education
 Discounts
 Other Assistance

Are you currently receiving any of the following benefits? Please check all that apply.

- Medicare
 Part D
 Medicaid
 Supplemental Social Income (SSI)
 Social Security Disability
 Veteran's Health Care Benefits
 Big Apple Rx (Pharmacy Discount Card)
 Extra Help/LIS through Medicare Prescription Drug Coverage
 Housing Choice Vouchers (Section 8)
 Public Housing
 Medicare Savings Programs (QMB, SLMB, or QI)
 Senior Community Service Employment Program (SCSEP)
 Supplemental Nutrition Assistance Program (SNAP)
 Low Income Home Energy Assistance (LIHEAP)
 TRICARE

Do you or your spouse (if married) have a condition that seriously limits your ability to work or take care of yourself? Yes No

Have you had an eye exam by a medical eye doctor (ophthalmologist) in the last three (3) years? Yes No

Are you legally blind? Yes No Are you dependent on family members or others for care? Yes No

Please choose any of the following that you may like more information about.

- Medicare
 Social Security (Old Age, Survivors, Disability, & Health Insurance Programs)
 Federal OASDHI Retirement System
 Railroad Retirement
 Caregiver and/or Respite Services
 Crisis Prevention Programs for Those Who Have Served
 Foreclosure Information & Assistance
 Free or Low-Cost Primary Health Care or Dental Services

Programs for: Blind
 Partially Sighted
 Deaf
 Hard of Hearing

Health Questions

We are also making sure that every child has access to basic health insurance. Do you know of any children, 18 years of age or younger, who do not have health insurance coverage? Yes No

Household

In what type of housing do you live?

- | | |
|--|---|
| <input type="checkbox"/> Own a home | <input type="checkbox"/> Rental |
| <input type="checkbox"/> Own a Mobile Home | <input type="checkbox"/> Boarding Home |
| <input type="checkbox"/> Live with Others | <input type="checkbox"/> Nursing Facility |
| <input type="checkbox"/> Assisted Living | <input type="checkbox"/> Low-Income Housing |
| <input type="checkbox"/> Homeless | |

Please provide the following information about your household. Include yourself and your spouse (if married) in each total.

Number of People in Household:

Number of People Who Depend on You For At Least One-Half of Their Financial Support:

Enter the total number of people who:

Are 60 years of age or older:

Have a Disability:

Do you pay property taxes on your place of residence? Yes No

Do you or your spouse (if married) pay your own gas and/or electric bill, either directly or indirectly? Yes No

Finances

Please tell us how much your household spends on a monthly basis for the items listed below. If you do not have exact numbers or your expenses change each month, please provide an estimate.

\$	Rent	\$	Mortgage	\$	Electricity	\$	Gas	Medical Expenses
\$	Telephone	\$	Other Utilities	\$	Dependent Care	\$	Water	\$

Please select the types of income you have. Enter the amount of your current **gross monthly** income in the "Self" section. If married, enter your spouse's income in the "Spouse" column. If you have income in both your and your spouse's name, enter it once either in the "Self" or "Spouse" section. Enter the income of any other people living in your household in the "Household" section.

Please note: If you do not know the exact amount of your income, please estimate the amount. Don't worry if you don't know all the answers. Just fill in the information you have now and then go to the next page.

<input type="checkbox"/> Work Income	\$	Self	\$	Spouse	\$	Household	\$	Total
<input type="checkbox"/> Pension and Retirement Benefit	\$	Self	\$	Spouse	\$	Household	\$	Total
<input type="checkbox"/> Social Security Retirement & Survivor Benefits	\$	Self	\$	Spouse	\$	Household	\$	Total
<input type="checkbox"/> Social Security Disability	\$	Self	\$	Spouse	\$	Household	\$	Total
<input type="checkbox"/> Supplemental Security Income	\$	Self	\$	Spouse	\$	Household	\$	Total

<input type="checkbox"/> Veteran's	\$	Self \$	Spouse \$	Household \$	Total
<input type="checkbox"/> Cash Assistance	\$	Self \$	Spouse \$	Household \$	Total
<input type="checkbox"/> TANF	\$	Self \$	Spouse \$	Household \$	Total
<input type="checkbox"/> Railroad Retirements Benefits	\$	Self \$	Spouse \$	Household \$	Total
<input type="checkbox"/> Dividends and Interest	\$	Self \$	Spouse \$	Household \$	Total
<input type="checkbox"/> Other Non-Work Income	\$	Self \$	Spouse \$	Household \$	Total

Please select the types of assets you have. Then enter the value of your assets in the "Self" section below. If married, enter your spouse's assets in the "Spouse" section. These are assets that your spouse owns separately from your assets. If your assets are owned in both you and your spouse's name, enter them once in either the "Self" or "Spouse" section. Enter the asset values of any other people living in your household in the "Household" section.

Please note: If you do not know the exact amount of your assets, please estimate the amount. Don't worry if you don't know all the answers. Just fill in the information you have now and then click on submit.

<input type="checkbox"/> Cash and Cash Equivalent	\$	Self \$	Spouse \$	Household \$	Total
<input type="checkbox"/> Retirement Accounts	\$	Self \$	Spouse \$	Household \$	Total
<input type="checkbox"/> Investment Accounts	\$	Self \$	Spouse \$	Household \$	Total
<input type="checkbox"/> Value of Home	\$	Self \$	Spouse \$	Household \$	Total
<input type="checkbox"/> Car	\$	Self \$	Spouse \$	Household \$	Total
<input type="checkbox"/> 2nd Car	\$	Self \$	Spouse \$	Household \$	Total
<input type="checkbox"/> Life Insurance: Cash Value	\$	Self \$	Spouse \$	Household \$	Total
<input type="checkbox"/> Life Insurance: Face Value	\$	Self \$	Spouse \$	Household \$	Total
<input type="checkbox"/> Burial Accounts: Revocable	\$	Self \$	Spouse \$	Household \$	Total
<input type="checkbox"/> Burial Accounts: Irrevocable	\$	Self \$	Spouse \$	Household \$	Total
<input type="checkbox"/> Other Assets	\$	Self \$	Spouse \$	Household \$	Total

COMPLETED BY: