Benefits Eligibility Form

Name: **Address:**

Phone: **City/State/Zip Code:**

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

- ☐ Own a home
- ☐ Own a Mobile Home
- ☐ Live with Others
- ☐ Assisted Living
- ☐ Homeless
- ☐ Rental
- ☐ Boarding Home
- ☐ Nursing Facility
- ☐ Low-Income Housing

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.

☐ Work Income	$	Self	$	Spouse	$	Household	$ 0	Total
☐ Pension and Retirement Benefit	$	Self	$ 0	Spouse	$ 0	Household	$ 0	Total
☐ Social Security Retirement & Survivor Benefits	$	Self	$	Spouse	$	Household	$ 0	Total
☐ Social Security Disability	$	Self	$	Spouse	$	Household	$ 0	Total
☐ Supplemental Security Income	$	Self	$	Spouse	$	Household	$ 0	Total

☐ Veteran's	$		Self	$		Spouse	$	Household	$ 0 Total
☐ Cash Assistance	$		Self	$		Spouse	$	Household	$ 0 Total
☐ TANF	$		Self	$		Spouse	$	Household	$ 0 Total
☐ Railroad Retirements Benefits	$		Self	$		Spouse	$	Household	$ 0 Total
☐ Dividends and Interest	$		Self	$		Spouse	$	Household	$ 0 Total
☐ Other Non-Work Income	$		Self	$		Spouse	$	Household	$ 0 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.

☐ Cash and Cash Equivalent	$		Self	$		Spouse	$	Household	$ 0 Total
☐ Retirement Accounts	$		Self	$		Spouse	$	Household	$ 0 Total
☐ Investment Accounts	$		Self	$		Spouse	$	Household	$ 0 Total
☐ Value of Home	$		Self	$		Spouse	$	Household	$ 0 Total
☐ Car	$		Self	$		Spouse	$	Household	$ 0 Total
☐ 2nd Car	$		Self	$		Spouse	$	Household	$ 0 Total
☐ Life Insurance: Cash Value	$		Self	$		Spouse	$	Household	$ 0 Total
☐ Life Insurance: Face Value	$		Self	$		Spouse	$	Household	$ 0 Total
☐ Burial Accounts: Revocable	$		Self	$		Spouse	$	Household	$ 0 Total
☐ Burial Accounts: Irrevocable	$		Self	$		Spouse	$	Household	$ 0 Total
☐ Other Assets	$		Self	$		Spouse	$	Household	$ 0 Total

COMPLETED BY:

01/03/24

CLEAR FORM

SAVE FORM