



Community Fund Ohio
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 www.communityfundohio.org

Are you reporting a new address for the Designated Advocate or Beneficiary?
 ___ YES ___ NO

Beneficiary Resource Record (BRR)

Please submit the completed form and supporting documentation to Community Fund via mail or fax.

1. Agreement Number (consists of 1-2 letters and 8 numbers): _____

2. Designated Advocate's (DA) Name: _____

Preferred Title: Mr. Mrs. Ms. Dr. _____

Address: _____

Is this a new address? No Yes

Phone Number: _____ Email Address: _____

3. Beneficiary's Name: _____

Preferred Title: Mr. Mrs. Ms. Dr. _____

Address: _____

Is this a new address? No Yes

What is the type of residence?

- | | | |
|--|---|---------------------------------------|
| <input type="checkbox"/> Owned by Beneficiary* | <input type="checkbox"/> Nursing Home* | <input type="checkbox"/> Group Home |
| <input type="checkbox"/> Rented by Beneficiary | <input type="checkbox"/> Assisted Living* | <input type="checkbox"/> ICF/ID |
| <input type="checkbox"/> No rent charged | <input type="checkbox"/> Subsidized Housing (HUD) | <input type="checkbox"/> Other: _____ |

4. Beneficiary's Income

- | | | |
|--|---|---|
| Wages | <input type="checkbox"/> Does not receive | <input type="checkbox"/> Receives \$ _____/mo |
| Social Security Retirement** | <input type="checkbox"/> Does not receive | <input type="checkbox"/> Receives \$ _____/mo |
| Social Security Disability Insurance** (SSDI) | <input type="checkbox"/> Does not receive | <input type="checkbox"/> Receives \$ _____/mo |
| Childhood Disability Benefit**
<small>(Adult child disabled prior to age 22 who receives parent's SS benefit)</small> | <input type="checkbox"/> Does not receive | <input type="checkbox"/> Receives \$ _____/mo |
| Supplemental Security Income** (SSI) | <input type="checkbox"/> Does not receive | <input type="checkbox"/> Receives \$ _____/mo |
| VA Benefits/Type: | <input type="checkbox"/> Does not receive | <input type="checkbox"/> Receives \$ _____/mo |
| Railroad Retirement Benefit | <input type="checkbox"/> Does not receive | <input type="checkbox"/> Receives \$ _____/mo |
| Child Support | <input type="checkbox"/> Does not receive | <input type="checkbox"/> Receives \$ _____/mo |
| Pension | <input type="checkbox"/> Does not receive | <input type="checkbox"/> Receives \$ _____/mo |
| Other | <input type="checkbox"/> Does not receive | <input type="checkbox"/> Receives \$ _____/mo |

Check this box if the Beneficiary is not receiving any income from any source

*Please include a copy of the current deed if any requests to pay housing related expenses will be submitted for a home owned by the beneficiary, even if the beneficiary resides elsewhere.

**Please attach a benefit verification letter if the Beneficiary receives any type of Social Security benefit.



- 5. Does the Beneficiary have any pending government benefit applications? Yes No
If yes, what type of application is pending? _____ Date filed: _____
- 6. Is the Beneficiary in a period of Medicaid restricted eligibility or other penalty? Yes No
If yes, when will the penalty end? _____
- 7. Has the Beneficiary been denied government benefits or have benefits ended? Yes No
If yes, please explain: _____
- 8. Medical Coverage / Health Insurance
 - a. Does the Beneficiary receive Medicaid? Pending – See Q. 5 above Yes No
If yes, what type of Medicaid? (check one)
 - Nursing Home RSS MAGI
 - Healthy Start Healthy Families Community
 - Aged, Blind, or Disabled (ABD) Other: _____
 - b. Does the Beneficiary receive a Waiver? Yes No
If yes, what type of Waiver? (check one)
 - PASSPORT Individual Options (I/O) Home Care
 - MyCare Ohio SELF Transitions
 - Assisted Living Level One Other: _____
 - c. Does the Beneficiary receive Medicare? Yes No
 - d. Does the Beneficiary receive Medicare Premium Assistance? Yes No
 - e. Does the Beneficiary have private or marketplace health insurance? Yes No
- 9. Does the Beneficiary have a Qualified Income or Miller Trust (QIT)? Yes No
- 10. Does the Beneficiary receive food assistance? Yes No

I declare that the information provided on this form is accurate and current.

Printed Name of Designated Advocate

Date

Signature of Designated Advocate

Community Fund strongly recommends purchasing a preneed funeral or other arrangements for the beneficiary. The procedure for distributions after the beneficiary's death is not the same as the procedure during the beneficiary's lifetime and payment for funeral or other expenses after the beneficiary's death may not be approved.

Please check this box if the beneficiary is deceased and provide the date of death: _____