Community Fund Ohio
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www.communityfundohio.org

Beneficiary Resource Record (BRR)

Please submit the competed 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: _____
   Phone Number: _____ Email Address: _____
   Address: _____
   Is this a new address? ☐ No ☐ Yes
   Beneficiary's Name: _____
   Phone Number (we will not contact the Beneficiary except as a matter of last resort): _____
   Address: _____
   Is this a new address? ☐ No ☐ Yes
   What is the type of residence for the Beneficiary?

☐ Owned by Beneficiary*	☐ Group Home	☐ Subsidized Housing (HUD)
☐ Rented by Beneficiary	☐ No Rent Charged	☐ Nursing Home**
☐ Assisted Living**		☐ ICF/ID**
Private Pay Period Until: _____		☐ Other: _____

*Please include a copy of the 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 the JFS Notice of Action showing the Beneficiary's Patient Liability charges.

3. Beneficiary's Income

Wages	☐ Does not receive	☐ Receives $_____/month
Social Security Retirement (SSA)***	☐ Does not receive	☐ Receives $_____/month
Social Security Disability Insurance (SSDI)***	☐ Does not receive	☐ Receives $_____/month
Childhood Disability Benefit*** (Adult child disabled prior to age 22 who receives parent's SS benefit)	☐ Does not receive	☐ Receives $_____/month
Supplemental Security Income (SSI)***	☐ Does not receive	☐ Receives $_____/month
VA Benefits/Type: _____	☐ Does not receive	☐ Receives $_____/month
Railroad Retirement Benefit	☐ Does not receive	☐ Receives $_____/month
Child Support	☐ Does not receive	☐ Receives $_____/month
Pension	☐ Does not receive	☐ Receives $_____/month
Food Stamps/SNAP	☐ Does not receive	☐ Receives $_____/month
Other: _____	☐ Does not receive	☐ Receives $_____/month

☐ **Check this box if the Beneficiary does not receive any income from any source**

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

4. Does the Beneficiary have any pending government benefit applications? ☐ Yes ☐ No
If yes, what type of application is pending? _____ Date filed: _____

5. Is the Beneficiary in a period of Medicaid restricted eligibility or other penalty? ☐ Yes ☐ No
If yes, when will the penalty end? _____
If yes, does the Beneficiary receive Medicaid health insurance (MyCare Ohio) during the penalty period? ☐ Yes ☐ No

6. Has the Beneficiary been denied government benefits or have benefits ended? ☐ Yes ☐ No
If yes, please explain: _____

7. Medical Coverage/Health Insurance

a. Does the Beneficiary receive Medicaid?

☐ Yes ☐ No

☐ Long-Term Care Medicaid eligible but in Restricted Coverage Period until _____

If yes, what type of Medicaid? (check one)

☐ Nursing Home ☐ Healthy Families ☐ MAGI ☐ RSS

☐ Healthy Start ☐ 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
☐ SELF ☐ MyCare Ohio ☐ Transitions
☐ Level One ☐ Assisted Living ☐ 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

8. Does the Beneficiary have a Qualified Income or Miller Trust (QIT)? ☐ Yes ☐ No

9. Does the Beneficiary have an Irrevocable Preneed Funeral and/or Burial Plot? ☐ 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: _____