



THE DISABILITY FOUNDATION

1401 S. Main Street, Suite 100, Dayton, OH, 45409 | Phone (937) 225-9939
www.disability-foundation.org

Beneficiary Profile

Please complete and return to the above office by mail or email.

1. Sub Account No. _____

2. Personal Representative Contact Information

Preferred Title Mr. Mrs. Ms. Other _____

Name _____ Phone _____

Address _____

City _____ State _____ Zip _____

Is this a new address? No Yes

Email address: _____

3. Beneficiary Contact Information (Report where the Beneficiary sleeps even if mailing address is different)

Preferred Title Mr. Mrs. Ms. Other _____

Name _____

Phone _____ Date of Birth _____

Address _____

City _____ State _____ Zip _____

Is this a new address? No Yes

Type of Residence	<input type="checkbox"/> Nursing Home	<input type="checkbox"/> Assisted Living	<input type="checkbox"/> Group Home
<input type="checkbox"/> ICF/ID	<input type="checkbox"/> Apartment	<input type="checkbox"/> Subsidized Housing (HUD, Section 8, etc.)	
<input type="checkbox"/> House Owned by Beneficiary	<input type="checkbox"/> House Owned by Family/Friend		
<input type="checkbox"/> Other	_____		

4. Beneficiary's Income Sources (Attach a Benefit Verification Letter if Beneficiary receives any type of Social Security benefit)

Wages	<input type="checkbox"/> Does Not Receive	<input type="checkbox"/> Receives per month \$ _____
Social Security Retirement	<input type="checkbox"/> Does Not Receive	<input type="checkbox"/> Receives per month \$ _____
Social Security Disability Insurance (SSDI)	<input type="checkbox"/> Does Not Receive	<input type="checkbox"/> Receives per month \$ _____
Childhood Disability Benefit <small>(Adult child disabled prior to age 22 receives parent's SS benefit)</small>	<input type="checkbox"/> Does Not Receive	<input type="checkbox"/> Receives per month \$ _____
Supplemental Security Income (SSI)	<input type="checkbox"/> Does Not Receive	<input type="checkbox"/> Receives per month \$ _____
VA Benefits/Type: _____	<input type="checkbox"/> Does Not Receive	<input type="checkbox"/> Receives per month \$ _____
Railroad Retirement Benefit	<input type="checkbox"/> Does Not Receive	<input type="checkbox"/> Receives per month \$ _____
Child Support	<input type="checkbox"/> Does Not Receive	<input type="checkbox"/> Receives per month \$ _____

Pension	<input type="checkbox"/> Does Not Receive	<input type="checkbox"/> Receives per month \$ _____
Other _____	<input type="checkbox"/> Does Not Receive	<input type="checkbox"/> Receives per month \$ _____
Check For Above Made Payable To	<input type="checkbox"/> Beneficiary	<input type="checkbox"/> Other _____

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

5. Does the Beneficiary have any government benefit applications pending? No Yes
 If yes, type of application _____ Date filed: _____
6. Is the Beneficiary in a period of Medicaid restricted eligibility or penalty period? No Yes
 If yes, date penalty period ends _____
7. Has the Beneficiary been denied government benefits or have benefits been terminated?
 No Yes – Explain: _____

8. Medical Coverage

Medicaid	<input type="checkbox"/> Does Not Receive	<input type="checkbox"/> Receives (Check type below)
Type:	<input type="checkbox"/> Nursing Home	<input type="checkbox"/> RSS
	<input type="checkbox"/> Healthy Start	<input type="checkbox"/> MAGI
	<input type="checkbox"/> Other	<input type="checkbox"/> Healthy Families
		<input type="checkbox"/> Aged, Blind, or Disabled (ABD)
Waiver	<input type="checkbox"/> Does Not Receive	<input type="checkbox"/> Receives (Check type below)
Type:	<input type="checkbox"/> Passport	<input type="checkbox"/> Home Care
	<input type="checkbox"/> Level One	<input type="checkbox"/> SELF
	<input type="checkbox"/> MyCare Ohio	<input type="checkbox"/> Transitions
		<input type="checkbox"/> Individual Options (I/O)
		<input type="checkbox"/> Assisted Living
		<input type="checkbox"/> Other _____

Does the Beneficiary Have a Qualified Income Trust / Miller Trust?	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Medicare	<input type="checkbox"/> Does Not Receive	<input type="checkbox"/> Receives
Marketplace Health Insurance	<input type="checkbox"/> Does Not Receive	<input type="checkbox"/> Receives / Mo. Premium \$ _____
Private Health Insurance	<input type="checkbox"/> Does Not Receive	<input type="checkbox"/> Receives / Mo. Premium \$ _____
Other Health Insurance _____	<input type="checkbox"/> Does Not Receive	<input type="checkbox"/> Receives / Mo. Premium \$ _____

9. Other Benefits

Food Assistance	<input type="checkbox"/> Does Not Receive	<input type="checkbox"/> Receives per month \$ _____
Medicare Premium Assistance	<input type="checkbox"/> Does Not Receive	<input type="checkbox"/> Receives
Other		
Irrevocable Preneed Burial	<input type="checkbox"/> Does Not Have	<input type="checkbox"/> Has Purchased

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

 Printed Name of Designated Advocate

 Date

 Signature of Designated Advocate

 Optional: Signature of Attorney assisting Personal Representative in completing this form

 Date

