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?

☐ Owned by Beneficiary*	☐ Nursing Home*	☐ Group Home
☐ Rented by Beneficiary	☐ Assisted Living*	☐ ICF/ID
☐ No rent charged	☐ Subsidized Housing (HUD)	☐ Other: _____

4. Beneficiary's Income

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