Community Fund Management Foundation

14955 W. Sprague Road, Suite 290 • Strongsville, OH 44136-1799
Fax: (216) 867-9783 • **www.cfmf.org**

Beneficiary Resource Record

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

1. Agreement No. _____ (Consists of 1-2 letters and 8 numbers)
2. Designated Advocate Contact Information

   Preferred Title ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Other _____

   Name _____ Phone _____

   Address _____

   City _____ State _____ Zip _____

   Is this a new address? ☐ No ☐ Yes
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 ☐ Nursing Home ☐ Assisted Living ☐ Group Home
☐ ICF/ID ☐ Apartment ☐ Subsidized Housing (HUD, Section 8, etc.)
☐ House Owned by Beneficiary ☐ House Owned by Family/Friend
☐ Other _____

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

Wages	☐ Does Not Receive	☐ Receives per month $ _____
Social Security Retirement	☐ Does Not Receive	☐ Receives per month $ _____
Social Security Disability Insurance (SSDI)	☐ Does Not Receive	☐ Receives per month $ _____
Childhood Disability Benefit (Adult child disabled prior to age 22 receives parent's SS benefit)	☐ Does Not Receive	☐ Receives per month $ _____
Supplemental Security Income (SSI)	☐ Does Not Receive	☐ Receives per month $ _____
VA Benefits/Type: _____	☐ Does Not Receive	☐ Receives per month $ _____
Railroad Retirement Benefit	☐ Does Not Receive	☐ Receives per month $ _____
Child Support	☐ Does Not Receive	☐ Receives per month $ _____
Pension	☐ Does Not Receive	☐ Receives per month $ _____
Other _____	☐ Does Not Receive	☐ Receives per month $ _____
Check For Above Made Payable To	☐ Beneficiary	☐ 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		☐ Does Not Receive	☐ Receives (Check type below)
Type:	☐ Nursing Home	☐ RSS	☐ MAGI
	☐ Healthy Start	☐ Healthy Families	☐ Aged, Blind, or Disabled (ABD)
	☐ Other _____		
Waiver		☐ Does Not Receive	☐ Receives (Check type below)
Type:	☐ Passport	☐ Home Care	☐ Individual Options (I/O)
	☐ Level One	☐ SELF	☐ Assisted Living
	☐ MyCare Ohio	☐ Transitions	☐ Other _____

Does the Beneficiary Have a Qualified Income Trust / Miller Trust?	☐ No	☐ Yes
Medicare	☐ Does Not Receive	☐ Receives
Marketplace Health Insurance	☐ Does Not Receive	☐ Receives / Mo. Premium $____
Private Health Insurance	☐ Does Not Receive	☐ Receives / Mo. Premium $____
Other Health Insurance _____	☐ Does Not Receive	☐ Receives / Mo. Premium $____

9. Other Benefits

Food Assistance	☐ Does Not Receive	☐ Receives per month $ _____
Medicare Premium Assistance	☐ Does Not Receive	☐ Receives
Other _____		
Irrevocable Preneed Burial	☐ Does Not Have	☐ 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 Designated Advocate in completing this form Date