Community Fund Management Foundation

17900 Jefferson Park, Suite 102 • Middleburg Heights, OH 44130
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)

Source		
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

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