NORTH CENTRAL
AREA AGENCY ON AGING

BenefitsCheckUp

You Have CHOICES

Connecticut State Department on Aging &
North Central Area Agency on Aging, Inc.

A Printable Comprehensive Benefits Checkup Questionnaire for Connecticut

The following questions are designed to determine your potential eligibility for benefits programs. You will receive the most complete Benefits Report if you answer all questions.

Name: _____ Alternate Contact: _____
Address:_____ Relationship:_____
_____ Address: _____
City: State:_____ Zip:_____ City: State:_____ Zip:_____
Phone Number:,_____ Phone Number::_____

Please note: The contact information that you provide above is solely used to return your Benefits Checkup Summary Report to you. This information is not entered into any NCOA computer system and never is it associated with the answers you provide. Therefore, you privacy is maintained.

BASICS

1. For whom are you completing this questionnaire? (Check only one)

Self _____Spouse _____Mother __Father _____Sister
_____Brother Client _____Test Case other

If your selected "Other" above, please specify (for instance, "Uncle")_____

2. Is the person for whom you're completing this questionnaire?_____Male _Female

3. Please enter the 5-digit zip code for the area in which you would like to screen: _____

DEMOGRAPHICS

4. What is your U.S citizenship/immigration status? (Check only one)

_____Citizen
_____Legal Resident
_____Other Qualified Alien
other

5. What is your marital status? (Check only one)

_____Married Living Separately
____Married
___Divorced
____ Single
_____Widowed

6. Please enter your month and year of birth: /_____

BENEFITS AND PUBLIC PROGRAMS

7. Are you currently receiving benefits from or participating in any of the following public programs? Answer this question only for the person for whom you are completing the questionnaire. Do not answer this question for other household members. (Check all that apply)

_____Medicare (currently enrolled or expected to be within the next 3 months)
_____Medicare Prescription Drug Plan (Part D)
_____Extra Help/Low Income Subsidy through Medicare Prescription Drug Coverage
_____Medicaid
_____Medicare Savings Programs (QMB, SLMB,ALMB)
These programs pay for the Medicare Part B Premium
_____Supplemental Nutrition Assistance Program (SNAP)
_____ConrtPACE (State Pharmacy Assistance Program)
_____Supplemental Security Income (SSI)
_____TRICARE .
__Veteran's Health Care Benefits
_____Low Income Home Energy Assistance Program (LIHEAP)
_____Public Housing
_____Section 8 Housing
_____Senior Community Service Employment Program (SCSEP)

VETERAN STATUS

8. Are you a U.S. Veteran?_____Yes _____No

9. Are you a Medicare eligible U.S. military retiree, including retired guards and reservists, who have served 20 or more years? _____Yes _____No

HEALTH

10. Do you currently have any following chronic conditions: arthritis, asthma, emphysema, bronchitis, cancer, depression, anxiety, diabetes, heart disease, high blood pressure, stroke, osteoporosis, or HIV/AIDS?

_____One chronic condition_____Two or more Chronic conditions_____None

11. Have you or your spouse (if married) been diagnosed with Alzheimer's disease or a related disorder? _____Yes No

12. Have you had an eye exam by a Medical Eye Doctor (Ophthalmologist) in the last three years? _____Yes _____No

ABILITY

13. Do you or your spouse (if married) have a condition that seriously limits your ability to work or take care of yourself?_____Yes ___ No

14. Are you legally blind? __Yes_____No

15. Are you dependent on family members or others for care? _____Yes _____No

HOUSING

16. In what type of housing do you live? (Check only one)

_____Own Home	_____Rent	_____Assisted Living
_____Own Mobile Home	_____Boarding Home	_____Subsidized Housing
_____Homeless/Shelter	_____Live with others	_____Nursing Facility

17. If you own a home, are both of the following Statements true?
- All of the owners of your home are 62 years of age or older?
- Your home is your principal residence (where you live the majority of the year)? Yes_____No

18. Please provide the following information about your household. Include yourself and your spouse (if married) in each total. Enter the total number of people who are:
_____Living in your household _____60 years old or older _____Disabled

19. Including yourself and your spouse, please enter the total number of people in your household who depend upon you or your spouse for at least one-half of their financial support. _____

FINANCIAL

20. Do you pay property taxes on your place of residence? __Yes No

21. Do you or your spouse (if married) pay your own gas/electric bill, either directly or included with the rent? _____Yes _____NO

INFORMATION AND ASSISTANCE

22. Please select the program(s) that may be of interest to you. (Check all that apply)

_____Medicare
_____Social Security-old Age, Survivors, Disability, and Health Insurance Programs (OASDHI)
_____Federal Retirement System
__Railroad Retirement
_____Adult Protective Services
_____Alzheimer's Programs
_____Assistive Technology Programs
_____Caregiver/Respite Services
_____Education Programs
_____Volunteer Programs (to serve as a volunteer)
___Employment Programs
Foreclosure Information and Assistance
_____Health Insurance Counseling (Medicare and other health care choices)
_____Home owners Insurance (for homes that have difficulty getting insurance
____Housing Programs (Senior and low-income housing)
_____Legal Assistance Programs
_____Primary health Care and Dental Service
_____Programs for the deaf and hard of hearing

FINANCIAL

23. Please tell us how much your household spends on a monthly basis for the items listed bellow if you do not have exact numbers or if your expenses vary by month, please provide an estimate:

_____.Rent Mortgage Electricity _____Gas _____Water
_____Telephone Other Utilities _____Dependant Care

24. How much money do you spend monthly on medical expenses that are not covered by health insurance?_____

25. Is your spouse/former spouse a U.S. Veteran?_____Yes ___No

26. If you indicated your spouse/former spouse is a U.S. Veteran, please let us know if they: _____Were honorable discharge

Most public and private benefits programs use your age and your financial information to determine if you qualify for their program. We will compare your answers to the financial questions to the eligibility rules for the programs in your state, and then give you a fact sheet on each program for which you may qualify.

27. Do you estimate that your monthly income, before taxes and other deductions are taken out, is less than or equal to $4,500 (include income from all sources such as: Social Security, pension's employment, cash assistance programs, etc.). Include spouse income, if spouse is living with you.

_____Income less than or equal to $4,500month_____Income greater than $4,500/mo

28. Do you estimate that the value of your assets, NOT including your home and car, is less than or equal to $100,000? (Include assets, such as: cash, bank accounts, stocks, bonds, CDs, other real estate, etc. If you have more than one car, do not include the most valuable.

_____Assets less than or equal to $100,000 _____Assets greater than $100.000

If you are a grandparent, or know a grandparent, raising grandchildren you are not alone. Six percent of US children under 18(3.9 million) live in grandparent-headed households. Additionally, over ten million children age 18 or under have no health insurance. Many families don't know their children are eligible for health insurance.

29. We want to make sure that every child has adequate health insurance. Do you know of any children, 18 or younger, who do not have health insurance coverage?

_____Yes _____No

PLEASE NOTE: If you do not know the exact amount of your income and your assets, please estimate the amount. Don't worry if you don't know all the answers. Just fill in the information you have.

30. Please enter your current gross monthly income in the "Self" Column below. Enter your spouse's income in the "Spouse" column. If any income is received jointly in both names, enter it in the "Joint" column. Enter the income of any others living in the household in the "Household" column.

	Self	Spouse	Joint	Household
Pension/ Retirement Benefits				
Dividends/ Interest				
Supplemental Security Income				
Social Security Disability				
Social Security Retirement/Survivor Benefits				
Railroad Retirements Benefits				
Veteran's Benefits				
Unemployment Insurance				
Worker's Compensation				
TANF				
Cash Assistance				
Other Non-Work Income				
Work Income				

31. Please enter the value of your assets in the "Self" column below. Enter the assets owned separately by your spouse in the "Spouse" column. If assets are owned jointly in both names, enter them in the "Joint" column. Enter assets of any others living in the household in the "Household" column.

	Self	Spouse	Joint	Household
Cash/ Cash Equivalent				
Automobile				
Automobile: Vehicle 2				
Value of Home				
Retirement Accounts				
Investment Accounts				
Life Insurance: Cash Value				
Life Insurance: Face Value				
Burial Accounts: Revocable				
Burial Accounts: Irrevocable				
Other Assets				

MEDICATION

32. Many Prescription drug companies offer discount programs to help older adults pay for your medication. To help us determine which discount programs may assist you, please list the full names of the medications you currently take. Print clearly, and attach an additional sheet if necessary.

OPTIONAL

33. How did you learn about Benefits Check up? (Check only one)

__AARP
_____Access to Benefits Coalition
_____Administration on Aging (AoA.gov)
_____Centers for Medicare and Medicaid Services (Medicare.gov)
_____CVS/pharmacy
_____Doctor or pharmacist
_____Google Search Engine
_____Kaiser Permanente
_____MyMedicareMatters.org
_____National Council on Aging Web Site
_____Newspaper, magazine or newsletter
_____Partnership for prescription Assistance (PPARx)
_____Pfizer
_____Poster, brochure or flyer
_____Radio
_____Social Security Administrator (SSA.gov)
__ ,State Unit on Aging/ Area
_____Agency on Aging
_____Television
_____Web MD
__Other

If you selected other; please specify: ———————————————

34. What is your race? (Check only one)

__White
_____Black or African-American
_____American Indian OJ;" Alaska Native
_____Asian
___ Native Hawaiian or Other Pacific __Islander
_____.Hispanic
___Other

If you selected other; please specify: ———————————————

Thank you for using Benefits Checkup!

Return you completed questionnaire to this address:

North Central Area Agency on Aging, Inc.
151 New Park Avenue, Box 75
Hartford, CT 06106