Information Gathering Form

Basic Information

Beneficiary name: Sandy Smith

Date of birth: 1/4/1987 Social Security number: 123-45-3456

Street address: 4758 Smith Rd

City/State/Zip: Rochester,NY 14622

Phone: 585-395-2856 Email: sandybeaches@gmail.com

Disabling Impairments/Conditions

How does the condition/impairment affect the ability to work?

Beneficiary continues to suffer from anxiety which leads to mental breakdowns. Her first severe case led to several months of hospitalization. Despite trying t0 return to work several times, she would relapse.

Date disability began: 1/8/2009 Date benefits began:

Household Composition

List the people in the household and their relationship to the beneficiary.

Name/Relationship: Diane Smith/Mother

Name/Relationship:

Name/Relationship:

Name/Relationship:

Name/Relationship:

Name/Relationship:

Do any of these household members receive benefits? If so, please explain:

No

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Educational Background

Completed high school: Yes

Completed a 4-year degree. Major: No

Post-graduate work. Major: ____

Vocational/technical college. Field: ____

Other training, apprenticeship. Field: ____

Vocational History:

Explore with the beneficiary their entire vocational history, pre- and post-disability.

Current employment status? Disabled, Collecting SSDI

Employment prior to receiving disability benefits:

Title: Clerk

Description of duties: Register duties and inventory

Dates of employment: 8/12 -4/13

Annual salary or hourly wage: $15/hr

Title: Clerk

Description of duties: Register Duties

Dates of employment: 6/11-5/12

Annual salary or hourly wage: $13/hr

Title: Clerk

Description of duties: Inventory stocking and register duties

Dates of employment: 7/10-4/11

Annual salary or hourly wage: $11-12.50/hr

Employment Since Receiving Disability Benefits:

Title: Has not been employed

Description of duties: ____

Dates of employment: ____

Annual salary or hourly wage: ____

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Title: ____________________

Description of duties: ____________________

____

Dates of employment: ____________________

Annual salary or hourly wage: ____________________

Title: ____________________

Description of duties: ____________________

____

Dates of employment: ____________________

Annual salary or hourly wage: ____________________

(For additional employment after disability began, add a separate page)

Financial Status:

Assets/resources (This question is necessary only for individuals interested in pursuing Medicaid benefits): $ None

Federal cash benefits or subsidy

SSDI amount: $ $635/month

DAC/CDB amount: $ ____________________

DWB amount: $ ____________________

SSI amount: $ ____________________

HUD subsidized housing: ____________________

State or Local Benefits

State SSI supplement amount: $ ____________________

SNAP amount: $ ____________________

TANF (FA, Safety Net) amount: ____________________

Unemployment Compensation amount: $ ____________________

Workers Compensation amount: $ ____________________

Health Benefits

- [x] Medicare • Part A • Part B • Part C • Part D
- [x] Medicaid or Medical Assistance
- [ ] State Health Insurance Risk Pool
- [ ] Private health insurance
- [ ] Other (describe): ____________________

Other Benefits

List any benefit not included above ____________________

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Work Expenses

This is particularly important for individuals who are already working. If not working, indicate when the expense will be necessary, e.g. first month of employment, every month, etc.

Description of expense: ____

____

____

Cost $______________________________ • Monthly? • One-time expense?

Date paid: ____

Description of expense: ____

____

____

Cost $______________________________ • Monthly? • One-time expense?

Date paid: ____

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Work Incentives Used:

(Gather this information by interviewing the beneficiary ***and*** verify it with the BPQY or a contact with the local SSA office, the HUD housing authority, the Medicaid office, etc.)

SSDI/DAC/DWB

Trial Work Period (TWP)

Number of months used: 0 Number of months remaining: ______

Additional information about TWP: ______

______

______

Cessation/grace period dates: ______

Impairment Related Work Expense dates used: ______

Describe expenses: ______

______

______

______

Subsidy and/or Special Condition

Description: ______

______

______

Value: $______ How determined? ______

______

______

Un-incurred Business Expense (self-employed only)

Describe expense: ______

______

______

______

Unpaid Help (self-employed only)

Description: ______

______

______

______

______

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Unsuccessful Work Attempt date(s): N/A

Section 301 Benefits date(s) ______

Expedited Reinstatement of Benefits date applied: ______

Status (Provisional, reinstated): ______

Number of EXR benefit months: ______

SSI

Student Earned Income Exclusion

Dates: ______

Earned Income Exclusion

Dates: ______

Impairment Related Work Expenses

Describe expenses: ______

Plan for Achieving Self Support

Brief description of plan: ______

Dates of plan: ______

Blind Work Expenses

Describe expenses ______

1619(b) Continued Medicaid

Dates: ______

Section 301 Benefits

Dates: ______

Expedited Reinstatement of Benefits

Date applied: ______

Status (provisional, reinstated): ______

Number of EXR benefit months: ______

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Other:

Medicaid Buy-in

Date enrolled: ____________________

HUD Earned Income Disregard

Date began: ____________________

Work incentives not listed above (e.g. state-specific): ____________________

____

____

____

Services and Supports:

(List the services and supports the individual has received in the past, or is currently receiving.)

Type of service/support: Work Incentive Benefit Guidance

Contact name: Andrew Hegeman

Street address: 180 Sewilo Hills Dr

____

City/State/Zip: Rochester, NY 16422

Phone: 716-397-8914 Email: drew.g.hegeman@gmail.com

Type of service/support: Social Service of Monroe County

Contact name: Brenda Winslow

Street address: 691 St Paul St #1

____

City/State/Zip: Rochester, NY 14605

Phone: 585-753-6960 Email: ____________________

Type of service/support: ____________________

Contact name: ____________________

Street address: ____________________

____

City/State/Zip: ____________________

Phone: ____________________ Email: ____________________

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Type of service/support: ____
Contact name: ____
Street address: ____
____
City/State/Zip: ____
Phone: ____________________________ Email: ____________________________

Type of service/support: ____
Contact name: ____
Street address: ____
____
City/State/Zip: ____
Phone: ____________________________ Email: ____________________________

Ticket to Work

Has the beneficiary assigned his/her Ticket to Work? • YES • NO
If yes, name of the Employment Network: ______________________________
Contact name: ____
Street address: ____
____
City, State ZIP: ____
Phone: ____________________________ Email: ____________________________

Additional Information

(List any information provided by the individual not included above)

____
____
____
____
____
____

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