APPLICATION FOR BENEFITS PLANNING

Date of Application: _____

Applicant name: _____

Address: _____ Zip _____

Email: _____

Phone: _____ Date of Birth: _____

Social Security Number: _____ Medicaid Number: _____

Is applicant their own guardian? _____ If not, who is? _____

Parent / Guardian Name: _____

Address: _____ Zip _____

Phone: (home) _____(work) _____(cell) _____

Is applicant their own payee? _____ If not who is? _____

Payee Name: _____

Address: _____ Zip _____

Phone: (home) _____(work) _____(cell) _____

MEDICAL

Primary Disability: _____Date of onset: _____

Secondary Disability: _____Date of Onset: _____

FINANCIAL

Current benefits (list amount received each month)

SSI _____ SSDI _____ Food Stamps _____ TANF _____

Housing Assistance (section 8) _____ Veteran Benefits _____ Worker's Comp _____

Other _____

Have you received past benefits that are now terminated? _____

EMPLOYMENT STATUS

Currently working _____ Self-employed _____ Seeking employment ____

Job offer pending _____ Considering Employment _____

If working: Place of Employment _____ Start Date: _____

Wage/Hour: $_____ Hours/week:_____

Check all that apply:

Contemplative Stage	**Preparatory Stage**	**Job Search Stage**	**Employment Stage**
☐ Considering work	☐ Connected to VR/EN	☐ Urgent benefit issue	☐ Already working
☐ Benefit concerns	☐ Identified work goal	☐Specific work goal	☐ Urgent benefit issues
☐ No employment goal	☐ Considering/In school	☐ Progress towards goal	☐ Changes in work
☐ Not connected to VR/EN	☐ PASS potential	☐ Interviewing	☐ IRWE process
☐ Other issues		☐ Job offer pending	☐ Subsidy possible

Notes:_____

_____

REFERRAL

Referral Source: _____

Address: _____ Zip _____

Phone: _____ Email: _____

Medicaid MCO: _____ Amerigroup____ AmeriHealth Caritas _____ United

Funding Source for Benefit Planning:_____

County of Legal Settlement: _____

Agencies / Individuals to receive reports: _____

Other interested people you want involved on your team: _____

_____

Person filling out form: _____

Candeo requires that the individual has knowledge of and support for this referral.

Applicant Signature: _____

Co-guardian: _____ Co-guardian: _____

Consent for Release of Information

TO: Social Security Administration

_____	_____	_____
Name	Date of Birth	Social Security Number

I authorize the Social Security Administration to release information or records about me via facsimile or postal correspondence, to:

NAME	**ADDRESS**
Jenna Bronson- Candeo	9550 White Oak Lane Johnston, IA 50131 Fax: 515-259-8109 Phone: 515-259-8110 ex. 2082

I want this information released because:

I need to have accurate and current information about my benefits to learn how these benefits would be affected by work. This will allow me to make informed decisions about working. ***Please send me a Benefits Planning Query (BPQY).***

Please release the following information:

_____ Social Security Number
_____ Identifying information (includes date and place of birth, parents' names)
__X__ Monthly Social Security benefit amount
__X__ Monthly Supplemental Security Income payment amount
_____ Information about benefits/payments I received from _____to_____
_____ Information about my Medicare claim/coverage from _____to_____
(specify)_____
_____ Medical records
_____ Record(s) from my file (specify)_____
__x__ Other (specify): See below.

Cash: Type of Benefit(s), current payment status, statutory blindness, date of disability onset, date of entitlement, Gross & net amount of benefits, others paid on the record, total family cash benefit, overpayment balance, monthly amount withheld.
Medical Reviews: Next medical review, medical re-exam cycle
Representation: Representative payee, authorized representative
Health Insurance: Type of Medicare (part A, part B, part C/D), start date, stop date, buy-in or subsidy, Medicaid eligibility, start date, stop date, buy-in or subsidy.
Title XVI (SSI) Work Exclusion: Blind work expenses, impairment-related work expenses, student earned income exclusions, pass exclusion, SSI earnings.
Title II (SSDI) Work Exclusion: Trial work months, start date, end date, number of months used, month of cessation, current SGA level.

I am the individual to whom the information/record applies or that person's parent (if a minor) or legal guardian. I declare under penalty of perjury that I have examined all the information on this form and it is true and correct to the best of my knowledge. I understand that anyone who knowingly gives a false or misleading statement about a material fact in this information, or causes someone else to do so, commits a crime and may be sent to prison, or may face other penalties, or both.

Signature:_____
(Show signatures, names and addresses of two people if signed by mark.)

Date: _____ Relationship: _____

Consent for Release of Information

TO: Social Security Administration

_____ _____ _____

Name Date of Birth Social Security Number

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_____ Information about my Medicare claim/coverage from _____to_____
(specify)_____
_____ Medical records
_____ Record(s) from my file (specify)_____
__X__ Other (specify): **Non-certified yearly totals of my earnings from my date of birth to the present.**

I am the individual to whom the information/record applies or that person's parent (if a minor) or legal guardian. I declare under penalty of perjury that I have examined all the information on this form and it is true and correct to the best of my knowledge. I understand that anyone who knowingly gives a false or misleading statement about a material fact in this information, or causes someone else to do so, commits a crime and may be sent to prison, or may face other penalties, or both.

Signature:_____
(Show signatures, names and addresses of two people if signed by mark.)

Date: _____ Relationship: _____

Form Approved
OMB No. 0960-0566

Social Security Administration
Consent for Release of Information

Please read these instructions carefully before completing this form.

When to Use This Form

Complete this form only if you want the Social Security Administration to give information or records about you to an individual or group (for example, a doctor, or an insurance company).

Natural or adoptive parents or a legal guardian, acting on behalf of a minor, who want us to release the minor's:

- **nonmedical** records, should use this form.
- medical records, should not use this form, but should contact us.

Note: Do not use this form to request information about your earnings or employment history. To do this, complete Form SSA-7050-F3. You can get this form at any Social Security office.

How to Complete This Form

This consent form must be completed and signed only by:

- the person to whom the information or record applies, or
- the parent or legal guardian of a minor to whom the **nonmedical** information applies, or
- the legal guardian of a legally incompetent adult to whom the information applies.

To complete this form:

- Fill in the name, date of birth, and Social Security Number of the person to whom the information applies.
- Fill in the name and address of the individual or group to which we will send the information.
- Fill in the reason you are requesting the information.
- Check the type(s) of information you want us to release.
- Sign and date the form. If you are not the person whose record we will release, please state your relationship to that person.