Benefits Planning Application

___ SSDI	___ DM
___ SSI	___ Ottumwa

Date_____

Last Name:_____ First Name:_____ MI:_____

Mailing Address:_____

County:_____ Active Email:_____

Phone:_____ Alternate Phone #1:_____

Date of Birth:_____ Social Security #: _____

Primary Disability/Disability of Record:_____

Health Insurance (Circle All That Apply): Medicare Medicaid Private Health Insurance Employer Insurance

Marital Status: ___ Single ___Married ___Divorced ___Widowed ___Separated

Is There A Spouse Or Dependent Children Receiving Benefits, And If So, What And How Much?_____
_____

Is Applicant Their Own Guardian? If Not, Please Complete The Following:

Guardian Name:_____

Address:_____Phone:_____

Is Applicant Their Own Payee? If Not, Please Complete The Following:

Representative Payee:_____

Address:_____ Phone:_____

Case Manager:_____ Phone:_____

Open VR Case: ___Yes ___No Counselor Name:_____

Ticket to Work Status:_____

If Working, Has Work/Wages Been Reported To Social Security? ___ Yes ___ No

Work History Since Being Entitled to Disability Benefits

Employer _____ Employer _____
Start Date _____ End Date _____ Start Date_____ End Date _____
Pay Rate _____ Hours _____ Pay Rate _____ Hours _____

Employer _____ Employer _____
Start Date _____ End Date _____ Start Date_____ End Date _____
Pay Rate _____ Hours _____ Pay Rate _____ Hours _____

*** If Not Currently Working, What Are Your Future Earning Income Goals Including How Many Hours And Rate Of Pay You Are Looking To Have The Benefits Plan Completed On. *This Is Necessary If The Person Is Not Working So The Benefits Plan Can Be Completed:*

_____

Current Benefits (please write in dollar amount, when applicable)

_____ SSDI _____ SNAP (Food Stamps)_____Habilitation Services
_____ SSI _____ TANF
_____ Medicare _____ HUD (Section 8 Housing)
_____ Medicaid _____ Energy Assistance
_____ Veteran's Benefits _____ Waiver Services

Have You Received Past Benefits That are Now Terminated?_____

If You Are Receiving Medicare, Are You Receiving Part D (Prescription Medication)? ___Yes____ No

Employment Stage

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

Agencies/Individuals who will receive the Report (Include Name & Address/Email):

_____

_____

_____

Goodwill requires that the beneficiary has knowledge of and support for this referral.

Applicant Signature:_____

Guardian Signature:_____

Please email or fax completed form to:
Kevin Lord
klord@dmgoodwill.org
Phone: 515.265.5323, Ext. 220
Fax: 515.265.0645

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:

Kevin Lord – Goodwill of Central Iowa
5355 NW 86th St.
Johnston, Iowa, 50131
Fax: 515-265-0645
Phone: 515-265-5353 Ext-220

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: _____

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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.

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