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: _____

Health Insurance (circle all that apply):
Medicare Medicaid Private Health Insurance Uninsured

FINANCIAL

Current benefits (list amount received each month)

SSI _____ SSDI _____ Food Stamps _____ TANF _____ Child Support _____
Housing Assistance (section 8) _____ Veteran Benefits _____ Worker's Comp _____
Child Support_____ Unemployment Insurance _____ Energy Assistance_____

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 (If not working, use goal) $_____

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: _____

_____

Voc. Rehab case open? _____ VR Counselor Name: _____

VR Counselor Phone Number: _____

What are your future employment goals? _____

_____

_____

_____

_____

Ticket to Work; Ticket Status: _____

Work History Since Benefits Entitlement

Employer: _____ Job Title: _____
Start Date: _____ End Date: _____
Pay Rate: _____ Hours/Week: _____

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Employer: _____ Job Title: _____

Start Date: _____ End Date: _____

Pay Rate: _____ Hours/Week: _____

Employer: _____ Job Title: _____

Start Date: _____ End Date: _____

Pay Rate: _____ Hours/Week: _____

Has work been reported to Social Security? _____

REFERRAL

Referral Source: _____

Address: _____ Zip _____

Phone: _____ Email: _____

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: _____

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

Applicant Signature: _____

Co-guardian: _____ Co-guardian: _____

Please fax or email completed form to:

Clark Young

cyoung@dmgoodwill.org

(641) 684-5401 ext. 40035

Fax: 641-684-4351

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**
Clark Young – Goodwill Industries of Central Iowa	5355 NW 86th St. Johnston, IA 50131 Fax: 641-684-4351 Phone: (641) 684-5401 ext. 40035

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: _____

Name:_____

D.O.B. _____

Medicaid # _____

GOODWILL INDUSTRIES OF CENTRAL IOWA
5355 NW 86th Street, Johnston, IA 50131, (515) 265-5323
CONSENT TO RELEASE OR OBTAIN INFORMATION

THIS IS A CONSENT FOR RELEASE OF INFORMATION ABOUT:

Name of Client | Birth Date | Social Security Number

Names of person or organization and address

Authorize: Clark Young, Goodwill Industries of Central Iowa, 5355 NW 86th Street, Johnston, IA 50131_____

To release or exchange with: Iowa Department of Human Services, 2309 Euclid Ave, Des Moines, IA 50314

The following specific information: All information related to Medicaid eligibitily, type of eligibility and requirements, date of entitlement, Low Income Subsidy, Medicare Savings Programs/State Buy-in.

In the following form(s): **written**, **verbal**, **faxed**, videotaped, audiotaped, **electronically** (circle all that apply)

Yes_____ No_____ Initial_____ Mental health information*
Yes_____No_____ Initial_____ Substance abuse information**
Yes_____ No_____ Initial _____Blood-borne pathogens (including HIV Information)

This information may be used only for the purpose of: **Benefits Planning & Analysis**
1. _____

I understand that I have the right to inspect the information to be disclosed upon proper notification to and under appropriate conditions established by **Goodwill Industries of Central Iowa.**

I can revoke my consent by writing to both the person giving and the person receiving the information. But any information already released may be used as stated on this consent. I understand the information is needed to plan services or to determine eligibility for services. This consent is valid until_____. This consent is not automatically renewable. It expires automatically at the end of the period specified unless revoked sooner. I have read this release form, or it has been read to me and I understand its content.

PROHIBITION ON DISCLOSURE

This form does not authorize redisclosure of medical information beyond the limits of this consent. Where information has been disclosed from records protected by federal law for alcohol/drug abuse records or by state law for mental health records, federal requirements (42C.F.R. Part 2) and state requirements (Iowa Code ch. 228) prohibits further disclosure without the specific written consent of the client, or as otherwise permitted by such law and/or regulations. A general authorization for the release of medical or other information is not sufficient for these purposes. Civil and/or criminal penalties may attach for unauthorized disclosure of alcohol/drug abuse or mental health information.
The attached medical and clinical information is confidential and legally privileged. The recipient may not further disclose the information without expressed consent of the client, as authorized by law.
This pertains equally to electronic records.

*Only clients 18 years of age or older or legal representatives can authorize release of mental health information.
**Only clients, regardless of age, can authorize release of substance abuse information.

_____
(Signature of Client or Client's authorized Representative) (Date)

_____
(Relationship to Client)

_____
(Staff) (Date)

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.