

## Key Public Benefits Questionnaire for Virginia

Welcome to the BenefitsCheckUp Printed Questionnaire! To learn about benefits you might be eligible for, please answer all of the questions to the best of your abilities. If you do not know the answer, you can skip the question. However, the more answers you provide, the more accurate your program list will be.

Once you complete the questionnaire, you or the agency you are working with will need to enter your answers into the BenefitsCheckUp online screening tool so that we can provide you with a personalized list of programs that you may be eligible for.

1. Who are you completing this for?

**Hint:** If the person you are answering the questions for is not listed in the options, please choose "Other" and fill in your relationship to that person in the box provided. For example, if you are filling this out for your female cousin, type "cousin" in the box and select "female" option for the question of whether she is male or female.

- |                                 |                                    |
|---------------------------------|------------------------------------|
| <input type="checkbox"/> Self   | <input type="checkbox"/> Spouse    |
| <input type="checkbox"/> Mother | <input type="checkbox"/> Father    |
| <input type="checkbox"/> Sister | <input type="checkbox"/> Brother   |
| <input type="checkbox"/> Client | <input type="checkbox"/> Test Case |
| <input type="checkbox"/> Other  |                                    |

If Other, please specify: \_\_\_\_\_

2. What is your gender?

- |                                |                                 |
|--------------------------------|---------------------------------|
| <input type="checkbox"/> Male  | <input type="checkbox"/> Female |
| <input type="checkbox"/> Other |                                 |

3. What is your year and month of birth? \_\_\_\_\_

4. What is your U.S. citizenship and/or immigration status?

**Hint:** Please select your U.S. citizenship or immigration status:

**U.S. Citizen:** a person born in the U.S., born to parents who are U.S. citizens, or declared a citizen by a court of law

**U.S. Legal Resident or Lawful Permanent Resident:** a person with a green card

**Other Qualified Alien:** a person who is a refugee, was granted asylum or withholding of deportation or was paroled in the U.S. for at least a year, or is Cuban or Haitian or a victim of domestic violence

**Other:** any other person who doesn't fit the above descriptions

- |  |   |
|--|---|
| <input type="checkbox"/> Citizen               | <input type="checkbox"/> Legal Resident |
| <input type="checkbox"/> Other Qualified Alien | <input type="checkbox"/> Other          |

5. If you entered the United States on or after 8/22/96, have you lived in the United States for at least 5 years in a row?

- |                              |                             |
|------------------------------|-----------------------------|
| <input type="checkbox"/> Yes | <input type="checkbox"/> No |
|------------------------------|-----------------------------|

6. What is your marital status?

**Hint:** Please select your current marital status:

**Married:** living as a couple, separated, or legally separated (the union must be a legally recognized marriage by the state from which the person is applying for benefits)

**Married Living Separately:** legally married but living in separate households

**Divorced:** having legally dissolved a previous marriage

**Single:** never married

**Widowed:** man or woman whose spouse has died

☐ Single

☐ Married Living Separately

☐ Widowed

☐ Married

☐ Divorced

7. What is your spouse's year and month of birth? \_\_\_\_\_

8. Are you currently receiving benefits from or participating in any of the following public programs? Answer this question only for yourself or for the person you are helping. Do not answer this question for other household members.

**Hint:** Please check all of the programs that you currently get help from. There may be programs in your state that base program guidelines on whether you participate in other programs. It is important that you answer this question because it may help you get other benefits.

☐ Medicare (currently enrolled or expect to be within the next 3 months)

☐ Medicare Prescription Drug Plan (Part D)

☐ Extra Help/LIS through Medicare Prescription Drug Coverage

☐ Medicaid

☐ Medicare Savings Programs (QMB, SLMB, or QI)

☐ Supplemental Nutrition Assistance Program (SNAP)

☐ Supplemental Security Income (SSI)

☐ Veteran's Health Care Benefits

☐ Low Income Home Energy Assistance Program (LIHEAP)

☐ Public Housing

☐ Housing Choice Vouchers (Section 8)

☐ Senior Community Service Employment Program (SCSEP)

9. Are you a U.S. veteran?

☐ Yes

☐ No

10. If you indicated you are a U.S. veteran, please let us know if you:

☐ Have a disability connected with your military service

☐ Were honorably discharged

11. Is your spouse (or former spouse) a U.S. veteran?

☐ Yes

☐ No

12. If you indicated that your spouse (or former spouse) is a U.S. veteran, please let us know if they:

☐ Have a disability connected with their military service

\_\_\_ Were honorably discharged

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

\_\_\_ Yes

\_\_\_ No

14. Do you or your spouse (if married) have a condition that seriously limits your ability to work or take care of yourself?

**Hint:** Please select yes if you (or your spouse, if married) have a condition which makes it difficult for you to do your activities of daily living (e.g. bathing, cleaning, and dressing) and/or to work.

Examples of conditions can include: chronic illness, disability which last at least 30 days, frailty, and/or functional impairment.

\_\_\_ Yes

\_\_\_ No

15. Are you legally blind?

**Hint:** Select yes if you cannot see (even when you are using glasses, contacts, or a magnifying glass) to do everyday activities such as: read a newspaper, read a cookbook, or see different traffic light colors.

\_\_\_ Yes

\_\_\_ No

16. Please choose any of the following that you may like more information about.

\_\_\_ Assistive Technology Programs

\_\_\_ Primary Health Care and/or Dental Services

\_\_\_ Programs for the Blind and Partially Sighted

\_\_\_ Programs for the Deaf and Hard of Hearing

17. In what type of housing do you live?

**Hint:** Please choose your current type of housing:

**Own Home:** you live in a house, apartment, coop, or condo that you own.

**Rental:** you live in a house, apartment, or condo that you rent.

**Own Mobile Home:** you own or lease the site on which your manufactured or mobile home (which you own) is located. In some states, in order to get tax reimbursements, your mobile home may need to be in a mobile home park.

**Boarding Home:** you live in a house or apartment with people who are not your family members.

**Live with Others:** you live in a community-based residential setting such as an Assisted Living Facility.

**Nursing Facility:** you live in a facility that provides 24-hour nursing care for chronic and/or long-term care illnesses and the facility provides regular medical supervision and rehabilitation therapy.

**Assisted Living:** you live in residential housing that provides services such as: meals; laundry; housekeeping; medication management; and help with bathing, eating, dressing, and/or using the toilet.

**Low-Income Housing:** you live in public housing offered to you because you have low income.

**Homeless or Live in Shelter:** you do not have a home that you own or rent. You may live in a shelter, with friends, or on the streets.

\_\_\_ Own Home

\_\_\_ Rental

\_\_\_ Own Mobile Home

\_\_\_ Boarding Home

\_\_\_ Live with Others

\_\_\_ Nursing Facility

\_\_\_ Assisted Living

\_\_\_ Low-Income Housing

\_\_\_ Homeless or Live in a Shelter

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:

Live in your household: \_\_\_\_\_

Depend on you for at least one-half of their financial support: \_\_\_\_\_

Are 60 years of age or older: \_\_\_\_\_

Have a disability: \_\_\_\_\_

19. Do you pay property taxes on your place of residence?

**Hint:** Please check yes if you pay taxes on your primary residence, a second home, vacation home, hunting cabin, etc. Even if you do not own your place of residence, you may be able to get some tax benefits if part of your rent pays for the property taxes. If this is the case, please answer yes to this question.

\_\_\_ Yes

\_\_\_ No

20. Do you or your spouse (if married) pay your own gas and/or electric bill, either directly or indirectly?

**Hint:** If you own or rent your place of residence, please check "Yes" if you pay your gas and/or electric bill directly to the utility company. If you are a renter and your utility costs are included in your rent payment, please select "Yes."

**Note:** If you are a renter and pay the utility costs indirectly through your rent, you will need to check with your state because every state has their own guidelines for providing energy assistance. Other rules may apply.

\_\_\_ Yes

\_\_\_ No

21. Please tell us how much your household spends, on a monthly basis, for the items listed below. If you do not have exact numbers or your expenses change each month, please provide an estimate.

Rent: \$ \_\_\_\_\_

Mortgage: \$ \_\_\_\_\_

Electricity: \$ \_\_\_\_\_

Gas: \$ \_\_\_\_\_

Water: \$ \_\_\_\_\_

Telephone: \$ \_\_\_\_\_

Other Utilities: \$ \_\_\_\_\_

Dependent Care: \$ \_\_\_\_\_

22. How much money do you spend, on a monthly basis, for medical expenses that are not covered by health insurance?

**Hint:** If you do not know the exact numbers or the number changes each month, please estimate how much money you spend each month on medical expenses.

\$ \_\_\_\_\_

23. What is your monthly income from the Senior Community Service Employment Program (SCSEP)?

**Hint:** Some benefit programs do not count income that you get from SCSEP. Entering your SCSEP income may help you meet the program guidelines. Please enter your SCSEP income here but do not enter it in any other income boxes so that your SCSEP income is not counted more than once towards your total income.

\$ \_\_\_\_\_

24. Please enter your current gross monthly income in the "Self" section below. If married, enter your spouse's income in the "Spouse" column. If you have income in both your and your spouse's name, enter it once either in the "Self" or "Spouse" section. Enter the income of any other people living in your household in the "Household" section. Please note: If you do not know the exact amount of your income, please estimate the amount. Don't worry if you don't know all the answers. Just fill in the information you have now and then go to the next page.

**Hint:** Income is payment you get. It can be either earned or unearned. Earned income is money you earn from working. Examples of unearned income are interest that is paid on your savings account, money you get from a pension, and so on. If you get other income during the year, instead of each month, you need to estimate what the payment would be per month. For example, if you get income only two times a year, you should add both payments and divide the total by 12 to get what the income would be each month.

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

25. Please enter the value of your assets in the "Self" column below. If married, enter your spouse's assets in the "Spouse" section. These are assets that your spouse owns separately from your assets. If your assets are owned in both you and your spouse's name, enter them once in either the "Self" or "Spouse" section. Enter the asset values of any other people living in your household in the "Household" section. Please note: If you do not know the exact amount of your assets, please estimate the amount. Don't worry if you don't know all the answers. Just fill in the information you have now and then click on submit.

**Hint:** Assets or resources include items such as cash, stocks, bonds, and IRAs. It also includes property such as cars and homes that can be turned into cash.

	Self	Spouse	Household
Cash and Cash Equivalent			
Car			
2nd Car			
Value of Home			
Retirement Accounts			
Investment Accounts			
Life Insurance: Cash Value			
Life Insurance: Face Value			

Burial Accounts: Revocable			
Burial Accounts: Irrevocable			
Other Assets			