BALTIMORE CITY HEALTH DEPARTMENT
OFFICE OF AGING AND CARE SERVICES
Maryland Access Point
417 E. FAYETTE STREET
6THFLOOR
BALTIMORE, MARYLAND 21202

Benefitscheckup Questionnaire

Name:_____

Address:_____

_____

City:_____ State:____ Zip:_____

Phone Number:_____

Alternate Contact:_____

Relationship:_____

Address:_____

City:_____ State:_____ Zip:_____

Phone Number:_____

Please Note: The contact information that you provide above is solely used to return your Benefitscheckup Summary Report to you. This information is not entered into any NCOA computer system and never is it associated with the answers you provide. Therefore, your privacy is maintained.

RETURN YOUR COMPLETED QUESTIONAIRE TO THE ADDRESS ABOVE

MARYLAND ACCESS POINT
YOUR LINK TO HEALTH & SUPPORT SERVICES
www.marylandaccesspoint.info

A Printable Comprehensive BenefitCheckUp Questionnaire for Maryland

Baltimore City Health Department
Office of Aging and CARE Services
Maryland Access Point
417 E. Fayette Street
6th Floor
Baltimore, Maryland 21202

BASICS

*1. Who are you completing this for?

[Check only one]

___ Self
___ Spouse
___ Mother
___ Father
___ Sister
___ Brother
___ Client
___ Test Case
___ Other

If you selected "Other" above, please specify (for instance, "Uncle"): _____

*2. Is the person for whom you're completing this questionnaire: ___ Male ___ Female

*3. What is the zip code for the area you would like to get help? _____

DEMOGRAPHIC

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

[Check only one]

___ Citizen
___ Legal Resident
___ Other Qualified Alien
___ Other

5. If you are not a citizen and 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? ___ Yes ___ No

6. What is your marital status?

[Check only one]

___ Single
___ Married
___ Married Living Separately
___ Divorced
___ Widowed

7. What is your month and year of birth? ____ / ____

BENEFITS AND PUBLIC PROGRAMS

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.

[Check all that apply]

___ **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-1)
___ Food Supplement Program
___ Maryland Senior Prescription Drug Assistance Program (SPDAP)
___ Social Security Disability
___ Supplemental Security Income (SSI)
___ TRICARE
___ 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)

VETERAN STATUS

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:

[Check all that apply]

___ Have a disability connected with your military service
___ Served during a time of war
___ 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:

[Check all that apply]

___ Have a disability connected with their military service
___ Were honorably discharged
___ Have a service-connected injury or illness that resulted in death

13. Are you or your spouse (or former spouse) a U.S. military retiree (including retired guards and reservists) who has served 20 or more years **AND** able to get Medicare? ___ Yes ___ No

HEALTH

14. Have you had an eye exam by a Medical Eye Doctor (Ophthalmologist) in the last three years? ___ Yes ___ No

ABILITY

15. Do you or your spouse (if married) have a condition that seriously limits your ability to work or take care of yourself? ___ Yes ___ No

16. Are you legally blind? ___ Yes ___ No

17. Are you dependent on family members or others for care? ___ Yes ___ No

HOUSING

18. In what type of housing do you live?

[Check only one]

- ____ Own Home
- ____ Rental
- ____ Own Mobile Home
- ____ Boarding Home
- ____ Live with Others
- ____ Nursing Facility
- ____ Assisted Living
- ____ Low-Income Housing
- ____ Homeless or Live in a Shelter

19. 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 are:

Living in your household ____
Dependent on you for at least one-half of their financial support ____
60 years old or older ____
Disabled ____

20. Do you pay property taxes on your place of residence? ____ Yes ____ No

21. Do you or your spouse (if married) pay your own gas and/or electric bill, either directly to the company or included in your rent? ____ Yes ____ No

EMPLOYMENT

22. Since you stated that you have a disability, does that disability make it difficult for you to work? ____ Yes ____ No

INFORMATION AND ASSISTANCE

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

[Check all that apply]

- ____ Medicare
- ____ Social Security - Old Age, Survivors, Disability, and Health Insurance Programs (OASDHI)
- ____ Federal Retirement System
- ____ Railroad Retirement
- ____ Adult Protective Services
- ____ Alzheimer's Programs
- ____ Assistive Technology Programs
- ____ Caregiver and/or Respite Services
- ____ Education Programs
- ____ Employment Programs
- ____ Foreclosure Information and Assistance
- ____ Health Insurance Counseling (Medicare and other health care choices)
- ____ Homeowner's Insurance (for homes that are difficult to insure)
- ____ Housing Programs (senior, low-income, or homeless)
- ____ Legal Assistance Programs
- ____ Pension Information and Assistance
- ____ Primary Health Care and/or Dental Services
- ____ Programs for the Blind and Partially Sighted
- ____ Programs for the Deaf and Hard of Hearing
- ____ Volunteer Programs (to serve as a volunteer)

If you are a grandparent (or know a grandparent) who is helping raise a grandchild, you are not alone. 7.5 million children in the United States (about 10 percent), live with a grandparent. Additionally, millions of children age 18 or under do not have health insurance and are unaware they may be able to get help paying their health coverage.

24. We are also making sure that every child has access to basic health insurance. Do you know of any children, 18 years of age or younger, who do not have health insurance coverage? ____ Yes ____ No

FINANCIAL

25. 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 $ _____

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

27. What is your monthly income from the Senior Community Service Employment Program? $ _____

28. Please indicate the number of children you claim as dependents on your federal income tax return. If you do not claim any children as dependents, please enter 0. ____

29. Please enter your current gross **monthly** income in the "Self" column 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 in the "Joint" column. Enter the income of any other people living in your household in the "Household" column.

	Self	Spouse	Joint	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				

30. Please enter the value of your assets in the "Self" column below. If married, enter your spouseâ€™s assets in the "Spouse" column. 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 in the "Joint" column. Enter assets of any other people living in your household in the "Household" column.

	Self	Spouse	Joint	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				

PRESCRIPTION MEDICATIONS

31. Many prescription drug companies offer discount programs to help older adults pay for medications. If you need help paying for your medications, please list the full names of the medications you currently take. **Print clearly**, and attach an additional sheet if necessary.