



Benefits Check Up

As required by HUD (Housing and Urban Development)

The following questions are designed to help the counselors assist clients to meet client's goals. Every question is required, so please be sure to answer each question. When the counselor calls you, they will ask the exact questions and you will have already had the time to write down the answers and have them ready in front of you for your convenience

1. For whom are you completing this questionnaire? (check only one)

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

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

3. Please enter the 5-digit zip code for the area in which you would like to screen for programs _____.

4. Please enter the client last name _____

5. Please enter the HCS Agency ID (enter last (4) digits after the "8") (we have already done this for you) **80058**

6. Please enter your month and year of birth _____

7. What is your U. S. citizenship/immigration status? (check only one)

- Citizen Other qualified alien Legal Resident Other

8. 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 consecutive years? Yes No

9. What is your current marital status? (check only one)

- | | |
|--|----------------------------------|
| <input type="checkbox"/> Married Living Separately | <input type="checkbox"/> Single |
| <input type="checkbox"/> Married | <input type="checkbox"/> Widowed |
| <input type="checkbox"/> Divorced | |

10. Are you currently receiving benefits from or participating in any of the following programs? Answer this question **only** for the person for whom you are completing the questionnaire. Do not answer this question for other household members. (check all that apply)

- | | |
|--|--|
| <input type="checkbox"/> Medicare (currently enrolled or expect to be within the next 3 months) | <input type="checkbox"/> Supplemental Security Income (SSI) |
| <input type="checkbox"/> Medicare Prescription Drug Plan (Part D) | <input type="checkbox"/> Veteran's Health Care Benefits |
| <input type="checkbox"/> Extra Help/Low Income Subsidy | <input type="checkbox"/> Low Income Home Energy Ass't LIHEAP |
| <input type="checkbox"/> Medicaid | <input type="checkbox"/> Public Housing |
| <input type="checkbox"/> Medicare Savings Programs (QMB, SLMB, Or QI-1) these programs pay for Medicare part B Premium | <input type="checkbox"/> Section 8 |
| <input type="checkbox"/> Florida Discount Drug Card Program (State Pharmacy Discount Card) | <input type="checkbox"/> Senior Community Service Employ (SCSEP) |
| | <input type="checkbox"/> Food Stamp Program/ SUNCAP |

11. Are you a U.S. Veteran? _____ No _____ Yes
12. Do you (or your spouse, if married) have a condition that seriously limits your ability to work or take care of yourself? _____ No _____ Yes
13. Are you legally blind? _____ No _____ Yes
14. Are you dependent on family members or others for care? _____ No _____ Yes
15. In what type of housing do you live? (check only one)
- | | |
|-----------------------|--------------------------|
| _____ Own Home | _____ Nursing Facility |
| _____ Rent Dwelling | _____ Assisted Living |
| _____ Own Mobile Home | _____ Subsidized Housing |
| _____ Boarding Home | _____ Homeless/Shelter |
16. People 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
- _____ 60 years or older
- _____ Disabled
17. Based upon the total number of people living in your household, including yourself and spouse, how many depend upon you or your spouse for **at least one-half** of their financial support?
- _____
18. Do you or your spouse (if married) pay your own gas/electric bill, either directly or included with the rent?
- _____ Yes _____ No
19. Please tell us how much your household spends monthly for (Please estimate if you do not have exact numbers or if your expenses vary by month.):
- | | |
|--------------------------|-------------------------|
| Rent \$ _____ | Water \$ _____ |
| Mortgage \$ _____ | Gas \$ _____ |
| Electricity \$ _____ | Telephone \$ _____ |
| Other Utilities \$ _____ | Dependent Care \$ _____ |
20. How much money do you spend monthly on medical expenses that are not covered by health insurance? \$ _____
21. What is your monthly income from the Senior Community Service Employment Program?
- \$ _____
22. 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 **zero (0)**
- _____

23. Please enter your current monthly income in the “Self” column below. Enter your spouse’s income in the “Spouse” column. If any income is received jointly in both names, enter it in the “Joint” column. Enter the income of any others living in the household in the “Household” column.

	Self	Spouse	Joint	Household
Pension/Retirement Benefits				
Dividends/Interest				
Supplemental Security Income				
Social Security Disability				
Social Security Retirement/Survivor Benefits				
Railroad Retirements Benefits				
Veteran’s Benefits				
Worker’s Compensation				
TANF				
Cash Assistance				
Other Non-Work Income				
Work Income				

24. Please enter the value of your assets in the “Self” column below. Enter the assets owned separately by your spouse in the “Spouse” column. If assets are owned jointly in both names, enter them in the “Joint” column. Enter assets of any others living in the household in the “Household” column.

	Self	Spouse	Joint	Household
Cash/Cash Equivalent				
Automobile: Vehicle 1				
Automobile: Vehicle 2				
Value of Home				
Retirements Accounts				
Investment Accounts				
Life Insurance: Cash Value				
Life Insurance: Face Value				
Burial Accounts:				
Other Assets				

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