THE DISABILITY FOUNDATION

1401 S. Main Street, Suite 100, Dayton, OH, 45409 | Phone (937) 225-9939
www.disability-foundation.org

Beneficiary Profile

Please complete and return to the above office by mail or email.

1. KeyBank Account No._____
2. Personal Representative Contact Information

   Preferred Title □ Mr. □ Mrs. □ Ms. □ Other _____

   Name_____ Phone_____

   Address_____

   City_____ State_____ Zip_____

   Is this a new address? □ No □ Yes

   Email address: _____
3. Beneficiary Contact Information (Report where the Beneficiary sleeps even if mailing address is different)

   Preferred Title □ Mr. □ Mrs. □ Ms. □ Other _____

   Name_____

   Phone_____ Date of Birth _____

   Address_____

   City_____ State_____ Zip_____

   Is this a new address? □ No □ Yes

Type of Residence	□ Nursing Home	□ Assisted Living	□ Group Home
□ ICF/ID	□ Apartment	□ Subsidized Housing (HUD, Section 8, etc.)	
□ House Owned by Beneficiary		□ House Owned by Family/Friend	
□ Other _____			

4. Beneficiary's Income Sources (Attach a Benefit Verification Letter if Beneficiary receives any type of Social Security benefit)

Wages	□ Does Not Receive	□ Receives per month $ _____
Social Security Retirement	□ Does Not Receive	□ Receives per month $ _____
Social Security Disability Insurance (SSDI)	□ Does Not Receive	□ Receives per month $ _____
Childhood Disability Benefit (Adult child disabled prior to age 22 receives parent's SS benefit)	□ Does Not Receive	□ Receives per month $ _____
Supplemental Security Income (SSI)	□ Does Not Receive	□ Receives per month $ _____
VA Benefits/Type: _____	□ Does Not Receive	□ Receives per month $ _____
Railroad Retirement Benefit	□ Does Not Receive	□ Receives per month $ _____
Child Support	□ Does Not Receive	□ Receives per month $ _____
Pension	□ Does Not Receive	□ Receives per month $ _____
Other _____	□ Does Not Receive	□ Receives per month $ _____
Check For Above Made Payable To	□ Beneficiary	□ Other _____

☐ **Check this box if the Beneficiary is not entitled to income from any source**

5. Does the Beneficiary have any government benefit applications pending? □ No □ Yes
   If yes, type of application_____ Date filed: _____
6. Is the Beneficiary in a period of Medicaid restricted eligibility or penalty period? □ No □ Yes
   If yes, date penalty period ends _____
7. Has the Beneficiary been denied government benefits or have benefits been terminated?
   □ No □ Yes – Explain: _____
8. Medical Coverage

Medicaid		□ Does Not Receive	□ Receives (Check type below)
Type:	□ Nursing Home	□ RSS	□ MAGI
	□ Healthy Start	□ Healthy Families	□ Aged, Blind, or Disabled (ABD)
	□ Other		
Waiver		□ Does Not Receive	□ Receives (Check type below)
Type:	□ Passport	□ Home Care	□ Individual Options (I/O)
	□ Level One	□ SELF	□ Assisted Living
	□ MyCare Ohio	□ Transitions	□ Other _____

Does the Beneficiary Have a Qualified Income Trust / Miller Trust?	□ No	□ Yes
Medicare	□ Does Not Receive	□ Receives
Marketplace Health Insurance	□ Does Not Receive	□ Receives / Mo. Premium $_____
Private Health Insurance	□ Does Not Receive	□ Receives / Mo. Premium $_____
Other Health Insurance _____	□ Does Not Receive	□ Receives / Mo. Premium $_____

9. Other Benefits

Food Assistance	□ Does Not Receive	□ Receives per month $_____
Medicare Premium Assistance	□ Does Not Receive	□ Receives
Other		
Irrevocable Preneed Burial	□ Does Not Have	□ Has Purchased

I declare that the information provided on this form is accurate and current.

Printed Name of Personal Representative

Date

Signature of Personal Representative