Case Manager: T TJ   I & R Only PASS IL Youth TTW Vet ILP CLAIM

Possible TTW / P-PLUS

LIFE Employment Solutions Intake

Staff Accepting: ____________________   Contact Date: ____________________

Request Via: Phone, Fax, in Person, Mail, E-mail, Web

Name: ____
First   Middle   Last

Address: ____
Street   City/State   Zip   County

Primary Phone (cell/home) ____________________ Alternate Phone (cell/home) ____________________

Gender M/F DOB__________ Race__________ SSN__________

Eligibility Statement: The above participant is eligible/ineligible for LIFE Inc. Center Services because of the following disabilities:

Disability on Record______________________________

Onset Date of Disability__________   Referring Agency Name____________________
Caseworker____________________

Email: ____________________ Phone # ____________________Fax #____________________

SSA Office __________ Income/Source SSI Amt.__________ SSDI Amt. __________ CDB Amt. __________ DWB Amt.__________

Other Income Amt. Private Pen.__________Alimony__________Unemployment__________ Work comp.__________

Living Arrangements: Single Married Widowed Divorced Separated

Children Under age 18 __________ Child Support Paid: __________ Child Support Received: __________

Spousal Income__________ Children's Benefits__________ Dependents on Benefits of Beneficiaries Work Record__________

Currently Working- No /PT/FT Hrs. Worked______ Rate of pay __________ Education- GED/HS Diploma/ College Hours/ Degree

Ind. Living: Y/N Dependent with Family and Friends: Y/N Assisted Living: Y/N Residential Care Facility: Level 1 / Level 2

Ever worked with any CIL? Y/N CIL Name: ____________________When? __________

Insurance: Medicaid Y/N #____________________Spenddown Amt: __________ TWHA PREMIUM $ __________

Medicare Part A __________Part B __________Part D-RX Plan ____________________ Eligible for Subsidy? Yes / No ________
(Low Income Extra Help for RX Coverage)

Medicare B premium paid for by**:** Self / QMB program / SLMB Program TTW Assigned? YES / NO ____________________

Private Insurance: YES/NO ____________________ # RX __________ Transportation: YES / NO Repairs? Yes/No
PASS Plan Needs Y/N -Date Active_______

Veteran Benefits: Compensation or Pension Cash Amt __________ Medical Benefits: __________ Registered Voter: YES / NO

Food Stamp Amt. ______ TANF Amt ______ Blind Pension ______ SAB_____ Suppl. N.H. Grant Amt ______Vendor Eligible: YES / NO

DFS Caseworker ____________________ Phone # ____________________ Fax #____________________

Subsidized Housing: Y/N Type ____________________ Amt. You Pay __________ Total Rent /Mortgage __________

Voc. Rehab. Contact: __________Phone# __________RSB Contact: __________Phone:__________

Dept. of Mental Health Contact ____________________ Phone# ____________________

Rep. Payee/Guardian/Public Administrator: Name: ____________________Phone#__________

Have you ever been convicted of a felony? Y/N Type of Conviction: ____________________

Expected Rate of Pay $_________/ hour   **Expected Number of Hours Weekly ____________________**

Notes/Goals:____

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