

Conventual Friars, Province of Our Lady of Consolation
c/o PO Box 6, Mt. St. Francis, IN 47146
Questionnaire: Information for Government Benefits

<p>PART I - BASIC INFORMATION</p> <p>1. Name: _____</p> <p>Birthdate: _____</p> <p>Social Security Number _____</p> <p>Name at birth: _____</p> <p>Previous religious name used: _____</p>	<p>Home Phone: _____</p> <p>Cell Phone: _____</p>
<p>2. In what city and state (or foreign country) were you born? _____</p>	
<p>3a. Are you a United States Citizen by birth?</p>	<p>Yes No</p>
<p>3b. Are you a naturalized United States citizen?</p>	<p>Yes No</p>
<p>PART II - POTENTIAL ELIGIBILITY FOR OTHER BENEFITS</p>	
<p>4. Have you ever:</p> <p style="padding-left: 40px;">Been married? Yes No</p> <p style="padding-left: 40px;">Worked for a railroad? Yes No</p> <p style="padding-left: 40px;">Been in Military Service? Yes No</p> <p style="padding-left: 40px;">Worked for the Federal Government? Yes No</p> <p style="padding-left: 40px;">Worked for a State /Local Government? Yes No</p> <p style="padding-left: 40px;">Worked for the government of a country other than the United States? Yes No</p> <p>If you answered "Yes" to any of these questions, please explain, including the beginning and ending dates:</p>	
<p>PART III – RESOURCES</p>	
<p>5. Do you own (or does your name appear on the title of) any vehicles? If "Yes", give year, make, and model:</p>	<p>Yes No</p>

<p>6. Do you own any life insurance policies? If "Yes", write in the name of the Life Insurance Company: _____</p>	<p>Yes No</p>
<p>7. Do you own, or do you co-own with another person, any of the following items?</p> <p>Do you own any Checking Accounts in your name? Yes No Do you co-own any Checking Accounts with someone else? Yes No Is your name on any local household accounts of your order? Yes No Do you own or co-own any Savings Accounts? Yes No Do you own or co-own any Credit Union accounts? Yes No Do you own or co-own any Christmas Club accounts? Yes No</p> <p>Account 1: Name of bank or financial institution: _____ Name of co-owner: _____ Current balance in account: _____</p> <p>Account 2: Name of bank or financial institution: _____ Name of co-owner: _____ Current balance in account: _____</p> <p><i>For more accounts please use the back of this form.</i></p> <p>Do you own or co-own any Certificates of Deposit (CDs)? Yes No Stocks or Mutual Funds? Yes No Bonds or Savings Bonds? Yes No Other items that can be turned into cash? Yes No</p> <p>If "Yes", give Face Value or description of the item: _____</p> <p>Do you have any Cash Money or Traveler's Checks in your possession? Yes No If "Yes", enter total amount? \$ _____</p>	
<p>8. Do you own (or co-own with some one else) any land, houses, buildings, burial plots, or real estate property?</p> <p>If "Yes", please explain:</p>	<p>Yes No</p>

PART IV – INCOME

9. Do you receive income from any of the following sources?

Social Security?	Yes	No
Supplemental Security Income (SSI)?	Yes	No
Railroad Retirement?	Yes	No
Veterans Administration?	Yes	No
Military Pension?	Yes	No
Unemployment Compensation?	Yes	No
Other Pension?	Yes	No
Insurance or Annuity Payments?	Yes	No
Interest (bank accounts, etc.)?	Yes	No
Rental/Lease Income?	Yes	No
Dividends/Royalties?	Yes	No
Other non-employment Income?	Yes	No

Type of income: _____ Frequency (wk/month/year): _____ Amount: _____

10. Do you receive regular (weekly, monthly, etc.) gifts of money from family or friends?

Yes No

If "Yes", how much and what frequency: _____

11. Do you work at a job with taxable salary or income ?
 (eg secular employment, or self-employment as a therapist or musician)
 Do you work at a job or ministry with stipend income (non-taxable income reimbursed to the religious order for your services) ?
 (eg parish ministry, diocesan positions, Mass stipends, etc.)

Yes No

Yes No

If "Yes", where do you work (name of parish, employer, etc.)?

Work Phone:

What is your annual salary or stipend amount? _____

If stipend income, is the money paid to you in your name and turned over to the order, or paid to the order directly?

Do you receive any other income you receive beside the income already mentioned in #9, 10, and 11 above?

Yes No

If "Yes", please explain:

Signature: _____

Date: _____

Medicare D Questionnaire

Name: _____

Have you already enrolled into Medicare D (Prescription Drug Plan)? YES NO

If YES, Please write plan name (PDP company): _____

PDP ID #: _____ Effective date: _____

What pharmacy do you regularly use for prescription medications?

If on Medicare D, please list any medications not being paid by your Medicare D:

Medication	Dosage
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Are you on EPIC or other State Prescription Assistance? EPIC#/card#: _____

Who is your primary physician?

Do you normally travel to any other states in the course of a year? YES NO

If YES, which states do you travel to? _____

Signature: _____

Date: _____

Conventual Friars, Province of Our Lady of Consolation
c/o PO Box 6, Mt. St. Francis, IN 47146

Designated Authorized Representative Letter

Name: _____

Birthdate: _____ SSN: _____

To Whom It May Concern:

I, _____, hereby designate ___Constance Neeson_____,
and/or ___Cindy McKay or Cindy Schmidt _____, employees of my religious
congregation, as my representative(s) for the purpose of making application, in my name,
for medical assistance and other benefits with the Medicaid Office, and also for conducting
business, in my name, with the Social Security Administration.

I authorize ___Constance Neeson and / or Cindy McKay or Cindy Schmidt_____ to
make, sign, file, and process the applications for medical assistance or other benefits;
and to obtain necessary information with respect to my assets, income, and medical
condition, including medical records, for the purpose of obtaining medical assistance and
other government eligibility benefits.

In the event that my application is denied, I authorize ___Constance Neeson _____
and/or ___ Cindy McKay or Cindy Schmidt ___ to request an appeal before the Hearings and
Appeals Section of the Medicaid Office or the Social Security Administration, and to
represent me at the hearing and in any judicial review.

Signature: _____

Date: _____

Witness (if signed with an X): _____

Name (Claimant) (Print or Type) *	Social Security Number * - -
Wage Earner (If Different)	Social Security Number - -

Part I APPOINTMENT OF REPRESENTATIVE

I appoint this person, Constance Neeson, LSW / Cynthia Schmidt,
(Name and Address)

to act as my representative in connection with my claim(s) or asserted right(s) under: Note: This Authorization is ongoing and continues indefinitely (Per GN 03910.060-A5)

- Title II (RSDI) Title XVI (SSI) Title XVIII (Medicare Coverage) Title VIII (SVB)

This person may, entirely in my place, make any request or give any notice; give or draw out evidence or information; get information; and receive any notice in connection with my pending claim(s) or asserted right(s).

I authorize the Social Security Administration to release information about my pending claim(s) or asserted right(s) to designated associates who perform administrative duties (e.g. clerks), partners, and/or parties under contractual arrangements (e.g. copying services) for or with my representative.

I appoint, or I now have, more than one representative. My main representative is _____

(Name of Principal Representative)

Signature (Claimant) *	Address *
Telephone Number (with Area Code) () -	Fax Number (with Area Code) () - Date

Part II ACCEPTANCE OF APPOINTMENT

I, Constance Neeson, LSW, hereby accept the above appointment. I certify that I have not been suspended or prohibited from practice before the Social Security Administration; that I am not disqualified from representing the claimant as a current or former officer or employee of the United States; and that I will not charge or collect any fee for the representation, even if a third party will pay the fee, unless it has been approved in accordance with the laws and rules referred to on the reverse side of the representative's copy of this form. If I decide not to charge or collect a fee for the representation, I will notify the Social Security Administration. (Completion of Part II satisfies this requirement.)

Check one: I am an attorney. I am a non-attorney who is participating in the direct fee payment demonstration project.

I am a non-attorney. I am not participating in the direct fee payment demonstration project.

I have been disbarred or suspended from a court or bar to which I was previously admitted to practice as an attorney. Yes No

I have been disqualified from participating in or appearing before a Federal program or agency. Yes No

I declare under penalty of perjury that I have examined all the information on this form, and on any accompanying statements or forms, and it is true and correct to the best of my knowledge.

Signature (Representative)	Address PO Box 39, St Mary of the Woods, IN 47876
Telephone Number (with Area Code) (812) 535 - 2970 or 535-2974	Fax Number (with Area Code) (812) 535 - 4279 Date

Part III (Optional) WAIVER OF FEE

I waive my right to charge and collect a fee under sections 206 and 1631(d)(2) of the Social Security Act. I release my client (the claimant) from any obligations, contractual or otherwise, which may be owed to me for services I have provided in connection with my client's claim(s) or asserted right(s).

Signature (Representative) Constance Neeson, LSW	Date
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Part IV (Optional) WAIVER OF DIRECT PAYMENT

by Attorney or Non-Attorney Eligible to Receive Direct Payment

I waive only my right to direct payment of a fee from the withheld past-due retirement, survivors, disability insurance or supplemental security income benefits of my client (the claimant). I do not waive my right to request fee approval and to collect a fee directly from my client or a third party.

Signature (Representative Waiving Direct Payment) Constance Neeson, LSW	Date
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Name (Claimant) (Print or Type) *	Social Security Number * - -
Wage Earner (If Different)	Social Security Number - -

Part I APPOINTMENT OF REPRESENTATIVE

I appoint this person, Constance Neeson, LSW / Cynthia Schmidt,
(Name and Address)

to act as my representative in connection with my claim(s) or asserted right(s) under: Note: This Authorization is ongoing and continues indefinitely (Per GN 03910.060-A5)

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This person may, entirely in my place, make any request or give any notice; give or draw out evidence or information; get information; and receive any notice in connection with my pending claim(s) or asserted right(s).

I authorize the Social Security Administration to release information about my pending claim(s) or asserted right(s) to designated associates who perform administrative duties (e.g. clerks), partners, and/or parties under contractual arrangements (e.g. copying services) for or with my representative.

I appoint, or I now have, more than one representative. My main representative is _____

(Name of Principal Representative)

Signature (Claimant) *	Address *	
Telephone Number (with Area Code) () - -	Fax Number (with Area Code) () - -	Date

Part II ACCEPTANCE OF APPOINTMENT

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I declare under penalty of perjury that I have examined all the information on this form, and on any accompanying statements or forms, and it is true and correct to the best of my knowledge.

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by Attorney or Non-Attorney Eligible to Receive Direct Payment

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Signature (Representative Waiving Direct Payment) Constance Neeson, LSW	Date
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Conventual Friars, Province of Our Lady of Consolation
c/o PO Box 6, Mt. St. Francis, IN 47146

Mailing Address Designation

To Whom It May Concern:

NAME (print): _____

Birth date: _____

Social Security Number: _____

I, hereby authorize the following changes to my eligibility information:

My residence is: _____

My mailing address is: **PO Box 6**
c/o Conventual Friars
Mt. St. Francis, IN 47146

This is the address of the Administrative Office for my religious order, the Conventual Friars, Province of Our Lady of Consolation (OFM Conv), of which I am a member. It is my wish that this address be used as my mailing address.

Please make this change to my benefits. Thank you.

Signed: _____

Date: _____

SOCIAL SECURITY ADMINISTRATION

Application for a Social Security Card

Form Approved
OMB No. 0960-0066

1	NAME _____ <small>TO BE SHOWN ON CARD</small>		First	Full Middle Name	Last
	FULL NAME AT BIRTH IF OTHER THAN ABOVE		First	Full Middle Name	Last
	OTHER NAMES USED				
2	MAILING ADDRESS _____ <small>Do Not Abbreviate</small>				
	Street Address, Apt. No., PO Box, Rural Route No.		City	State	ZIP Code
3	CITIZENSHIP _____ <small>(Check One)</small>	<input type="checkbox"/> U.S. Citizen	<input type="checkbox"/> Legal Alien Allowed To Work	<input type="checkbox"/> Legal Alien Not Allowed To Work (See Instructions On Page 2)	<input type="checkbox"/> Other (See Instructions On Page 2)
4	SEX _____	<input type="checkbox"/> Male	<input type="checkbox"/> Female		
5	RACE/ETHNIC DESCRIPTION _____ <small>(Check One Only - Voluntary)</small>	<input type="checkbox"/> Asian, Asian-American or Pacific Islander	<input type="checkbox"/> Hispanic	<input type="checkbox"/> Black (Not Hispanic)	<input type="checkbox"/> North American Indian or Alaskan Native
6	DATE OF BIRTH _____ <small>Month, Day, Year</small>	7	PLACE OF BIRTH _____ <small>(Do Not Abbreviate)</small>		<small>Office Use Only</small>
			City	State or Foreign Country	FCI
8	A. MOTHER'S NAME AT HER BIRTH _____		First	Full Middle Name	Last Name At Her Birth
	B. MOTHER'S SOCIAL SECURITY NUMBER (See instructions for 8B on Page 2) _____		_ _ _ _ - _ _ _ - _ _ _ _		
9	A. FATHER'S NAME _____		First	Full Middle Name	Last
	B. FATHER'S SOCIAL SECURITY NUMBER (See instructions for 9B on Page 2) _____		_ _ _ _ - _ _ _ - _ _ _ _		
10	Has the applicant or anyone acting on his/her behalf ever filed for or received a Social Security number card before? <input type="checkbox"/> Yes (If "yes", answer questions 11-13.) <input type="checkbox"/> No (If "no," go on to question 14.) <input type="checkbox"/> Don't Know (If "don't know," go on to question 14.)				
11	Enter the Social Security number previously assigned to the person listed in item 1. _____		_ _ _ _ - _ _ _ - _ _ _ _		
12	Enter the name shown on the most recent Social Security card issued for the person listed in item 1. _____		First	Middle Name	Last
13	Enter any different date of birth if used on an earlier application for a card. _____		_____ <small>Month, Day, Year</small>		
14	TODAY'S DATE _____ <small>Month, Day, Year</small>		15 DAYTIME PHONE NUMBER () - _____ <small>Area Code Number</small>		
16	I declare under penalty of perjury that I have examined all the information on this form, and on any accompanying statements or forms, and it is true and correct to the best of my knowledge.				
	YOUR SIGNATURE _____		17 YOUR RELATIONSHIP TO THE PERSON IN ITEM 1 IS: <input type="checkbox"/> Self <input type="checkbox"/> Natural Or Adoptive Parent <input type="checkbox"/> Legal Guardian <input type="checkbox"/> Other (Specify) _____		
DO NOT WRITE BELOW THIS LINE (FOR SSA USE ONLY)					
NPN		DOC	NTI	CAN	ITV
PBC	EVI	EVA	EVC	PRA	NWR DNR UNIT
EVIDENCE SUBMITTED				SIGNATURE AND TITLE OF EMPLOYEE(S) REVIEWING EVIDENCE AND/OR CONDUCTING INTERVIEW	
				DATE	
				DATE	