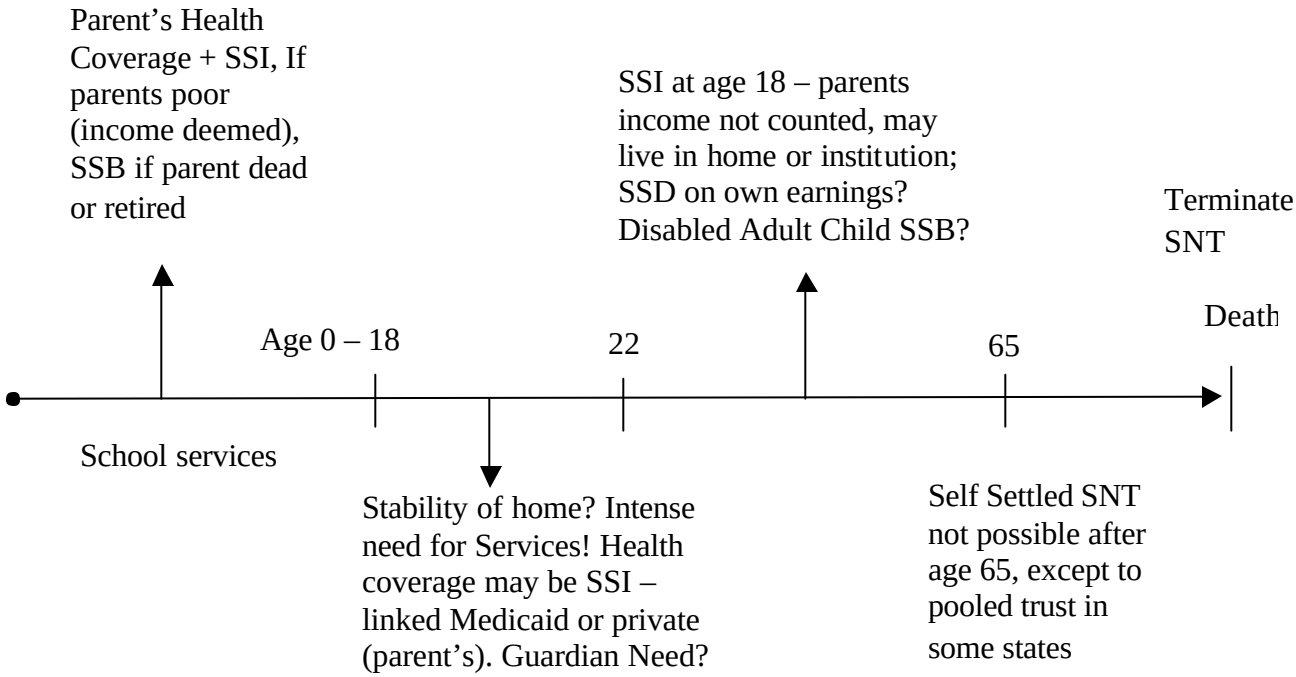
PUBLIC BENEFIT REVIEW

Name of Disabled Person: _____
Date of Birth: _____ Age: _____ SS #: _____
Name of Person Filling Out This Form: _____
Date: _____
If the disabled person is receiving social security monthly income of any kind, please provide the name of the SSA representative payee (if any): _____

From which **public programs** is the disabled person receiving help? Please check below and attach verification of the benefit or eligibility if available.

_____ SS retirement - Amount: $_____/month
_____ SS disability - Amount: $_____/month
$____ on parent's account as a disabled child before age 22?
(DAC – children's SSB OAR 461-135-0830)
$____ on beneficiary's own work quarters (work history of child)
_____ Pickle Amendment – SSB cost of living raises takes out of SSI
_____ SSI (up to $552/month in 2003)
_____ Medicare
_____ Medicaid - long term care program? Mental health? Other?
_____ Oregon Health Plan (not regular Medicaid)
_____ Long term care services - nursing, foster, group homes
_____ Mental Health Services - where?
State Hospital? ____ Statutory Claim Amount: $_____
Psychiatric Security Review Board Ordered? _____
Community Mental Health Provider? _____