COUNTYWIDE BENEFITS ENTITLEMENTS SERVICES TEAM
(C.B.E.S.T.)
COMMUNITY REFERRAL FORM

C.B.E.S.T.

Referral Date: _____

Referral Type:	☐ **C4**: SSI/SSDI/CAPI Advocacy for Homeless/At Risk ☐ **C5:** Veteran's Benefits Advocacy Homeless/At Risk ☐ **C6:** SSI/SSDI Advocacy for Inmates

Referring Agency:	**Staff Name/Title:**
Alternate Staff Name:	**Cell/Office Phone:**
Phone & Email:	**Email:**

IDENTIFYING INFORMATION

First Name:		**Middle Name:**		**Last Name:**		
Known Aliases:		**SSN#:**			**Place of Birth:**	
DOB:	**Age:**	**18-24 (TAY):** ☐	**62-65:** ☐	**65+:** ☐	**CHAMP ID:**	**GR CASE #:**

Gender Identification:		**Marital Status:**	
☐ Male	☐ Female	☐ Single	☐ Living with Partner
☐ Transmasculine, Female to Male, Transgender Male, Trans Man	☐ Transfeminine, Male to Female, Transgender Female, Trans Woman	☐ Separated*	☐ Widowed*
		☐ Divorced*	☐ Other*
		☐ Married/Civil Union*	☐ Client Doesn't Know
☐ Genderqueer, neither exclusively male nor female, nonbinary or gender non-conforming		☐ Client Chose not to Answer	*If ever married, please answer the following two questions:
		(1) How long were you married?	
☐ Client Doesn't Know	☐ Client Chose not to Answer	(2) Full Name, DOB and SS# of your spouse:	

CONTACT INFORMATION

Mailing Address:			
Alternate Address:			
City:	State:	Service Planning Area (SPA):	Zip Code:
Primary Phone:	Alternate Phone:	Email Address:	

DEMOGRAPHIC INFORMATION

Ethnicity:	**Race:**	
☐ Hispanic/Latino	☐ American Indian or Alaska Native	☐ White
☐ Non-Hispanic/Latino	☐ Asian	☐ Other (list):
☐ Client Doesn't Know	☐ Black or African American	☐ Client Doesn't Know
☐ Client Chose not to Answer	☐ Native Hawaiian/Other Pacific Islander	☐ Client Chose not to Answer

Have you served in the U.S. Armed Forces? ☐ Yes ☐ No

☐ Client doesn't know	☐ Client Chose not to Answer	Dates of Service:
Branch of Service:	Discharge Status:	

Have you been incarcerated in the last year? ☐ Yes ☐ No

Length of time:	Name of Facility:	Release Date:	On Probation or Parole?	☐ Yes ☐ No
Primary Language:	☐ English	☐ Other (please list):		

Can you communicate (read, write and/or speak) in English? ☐ Yes ☐ No	What is the highest level of education/grade completed? _____ Did you receive Special Education Services? ☐ Yes ☐ No

CITIZENSHIP & IMMIGRATION INFORMATION

Citizenship/Immigration Status:	
☐ U.S. Citizen	Country of Origin:
☐ Eligible Non-Citizen (CAPI)	Alien Number:
☐ Ineligible Non-Citizen	Entry Date:

PRE-SCREENING: CBEST PROGRAM ELIGIBILITY*

Q1a. Is the client currently on Medi-Cal? **Yes:** ☐ **No:** ☐

Please check ONE: Medi-Cal ☐; Medicare ☐; Med-Cal + Medicare ☐

Q1b. Is the client potentially eligible for Medi-Cal OR receiving one of the below? **Yes:** ☐ **No:** ☐

Please check all that apply:

GR ☐; CalWORKS ☐; Refugee Cash Assistance ☐; VASH Voucher: ☐; Other Federal Housing Subsidy ☐

Q2. Is the client currently Homeless or at risk of homelessness? Please check ONE below.

Homeless (currently NOT housed) Yes: ☐ Total Number of Months Homeless: _____ No: ☐

At risk of homelessness (currently housed) Yes: ☐ No: ☐

INITIAL SCREENING OF CLIENTS FOR SSI, SSDI, CAPI, OR VETERANS BENEFITS ELIGIBILITY*

Q1. Is the client interested in applying for SSI, SSDI, CAPI, or Veterans benefits? Yes: ☐ **No:** ☐

Reason (if no) : _____

Q2. Is the client 65+ or within 4 months of turning age 65 or older? Yes: ☐ **No:** ☐ **Please check ONE below.**

65 or older ☐ Within 4 months of turning age 65 ☐

Q3. Is the client currently working? Yes: ☐ **No:** ☐

If yes: How many hours per month? _____ How much money does the client earn from working per month? $_____

Q4. Has the client applied for SSI or SSDI before as an adult (18+)? **Yes:** ☐ **No:** ☐

If yes: Date and type of last application (SSI, SSDI, etc.): _____

Disposition: ☐ Approved ☐ Denied ☐ Unknown

Does the client currently have an attorney or other advocate assisting them with a benefits application? Yes: ☐ No: ☐

If yes please list their name and contact information: _____

Q5. What is the client's total monthly income from any source? Please list below.

SSI: ☐ Amount: $_____

SSDI: ☐ Amount: $_____

CAPI: ☐ Amount: $_____

Veterans benefits: ☐ Amount: $_____

Other Source: _____ Amount: $ _____

Other Source: _____ Amount: $ _____ TOTAL: $_____

Q6. Does the client have over $2000 in cash or other resources? Yes: ☐ **No:** ☐ **(If yes, please list below.)**

Source: _____ Amount: $ _____

Source: _____ Amount: $ _____

Source: _____ Amount: $ _____ TOTAL: $ _____

Q7. What is/are the disability (ies) or health condition(s) that makes the client unable to work? Please list below.

Physical disability(ies): Yes: ☐ No: ☐

List: _____

Will these disabilities be resolved in less than one year? Yes: ☐ No: ☐

Mental health disability(ies): Yes: ☐ No: ☐

List: _____

Did any of the mental or physical health disabilities listed above start while in military service? Yes: ☐ No: ☐

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Prioritization Level:

☐High - next day appointment if possible (metastatic cancer, renal failure, terminal diagnosis, legally blind/deaf, bed confinement/immobility)

☐Medium - appointment within a week (chronically homeless or living on the streets with severe physical or mental health impairments, TAY and living on the streets)

FLAGS:

☐ Veteran ☐ TAY ☐62-65 ☐65+ ☐homeless

☐ already on benefits ☐applied for benefits in the past ☐working at or above SGA ☐total income above $800/month

☐ total resources over $2000 ☐ disability(ies) expected to resolve within a year

**Please note: The information contained herein reflects eligibility criteria for the CBEST Program ONLY and does not reflect eligibility criteria from the Social Security Administration. The information in this document is not intended to convey or constitute legal advice on potential eligibility for government benefits.*