**Federal Benefit Eligibility Assessment**

*This form must be used to complete an assessment to determine the potential eligibility for federal benefits for children. This must be completed within 60 days of case opening. If the child is deemed not eligible initially, a review using this assessment document, must be completed at least annually thereafter. Follow the directives on the form to complete the assessment.*

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| --- | --- | --- |
|  **Child Name**        | **DCN**        | **DOB**        |
|  **Worker Name**       |  **Legal Status 1 Date**  |
| **Assessment Date**  Click or tap to enter a date. |  **Assessment Type**  Choose an item. |

**Part 1-Eligibility Factors**

**Please check all boxes that apply for the child:**

[ ]  The child has a significant medical or mental health diagnosis.

[ ]  The child has a disability or potentially has a disability.

[ ]  The child has an IEP.

***For the below responses, parent is defined as biological, adoptive, step, legal guardian, and parents who have had their rights to the child terminated, but the child has not been adopted by another person.***

**Please check all boxes that apply for the child:**

[ ]  The child has a parent who served or currently serves in the military.

[ ]  The child has a parent who was employed by the U.S. Railroad.

[ ]  The child has a parent who is deceased.

[ ]  The child has a parent who has a disability.

**If any of the above boxes were checked, provide additional details that may assist to determine the child’s eligibility status in the space below:**

**Part 2-Current Benefits**

**Please check the boxes below to indicate which types of federal benefits the child is currently receiving: (Select all that apply)**

[ ]  Supplemental Security Income (SSI)

[ ]  Retirement, Survivors and Disability Insurance (RSDI)

[ ]  Veteran’s Administration (VA)

[ ]  U.S. Railroad Retirement Board (RRB)

**If any of the boxes above were selected, indicate who the current representative payee is and the benefit amount (if known):**

Current representative payee information (name, relationship, contact info):

Benefit amount: $

Person eligible for the benefit:

**Part 3-Outcome**

**Select only one option below to indicate the assessment outcome.**

[ ]  **Child may be eligible for or is receiving benefits**. (Select this option when any box in Part 1 or 2 was checked. Upload form to OnBase. Email form to the [DFAS Social Security Specialist](https://dssintranet.mo.gov/dss-childrens-division/wp-content/uploads/sites/4/2022/01/SocialSecurityMapContactListUpdated01.pdf).)

[ ]  **There are no factors that indicate an application for benefits should be completed.** (Upload form OnBase. Review the child’s circumstances at least annually using this form.)

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|       |  |       |
| Worker Name | Signature | Date |

|  |  |  |
| --- | --- | --- |
|       |  |       |
| Supervisor Name | Signature | Date |