SOUTHWESTERN PENNSYLVANIA HUMAN SERVICES

REPRESENTATIVE PAYEE PROGRAM REFERRAL

Please complete all the pages in the referral packet and FILL IN ALL BLANKS. All information provided in the referral packet is confidential.

REFERRAL SOURCE INFORMATION

Consumer Name: _____ Date: _____

Referral Source: ☐ Self ☐ Other: _____

Referral Phone: _____ Referral Email: _____

CONSUMER PERSONAL INFORMATION

Birthdate: _____ Age: _____ Gender: _____

Social Security #: _____

How long a Butler County resident? _____

Marital Status: Single / Married / Separated / Divorced / Widow / Widower *(circle one)*

Military Service: ☐ Yes – Branch: _____ Years Served: _____
☐ No

CONSUMER CONTACT INFORMATION

Street Address: _____ Apt. #: _____

City/State/ZIP: _____

Is there an alternative address? ☐ Yes ☐ No

If yes, please provide: _____

Phone Number: _____ Cell / Home / Work *(circle one)*

CONSUMER FINANCIAL INFORMATION

Current Monthly Income: $_____

Source: _____

Bank Account: ☐ Yes – Type: _____ Bank Name: _____
☐ No

Mental Health Association in Butler County
140 N Elm Street, Butler PA 16001
724-287-1965 · FAX 724-287-7090

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PAYEE STATUS

Please describe the reason for requesting Payee Services:

How does the consumer's mental health symptoms impact their ability to manage their own finances?

Does the consumer currently have a Payee? ☐ Yes ☐ No *If yes, please complete the information below.*

Name of Payee: _____ Phone Number: _____

Relationship to Consumer: _____

Reason they are no longer the Payee: _____

_____

Did the consumer have a Payee in the past? ☐ Yes ☐ No *If yes, please complete the information below.*

Name of Payee: _____ Phone Number: _____

Relationship to Consumer: _____

Reason they are no longer the Payee: _____

_____

Does the consumer have a Legal Guardian? ☐ Yes ☐ No *If yes, please complete the information below.*

Name of Payee: _____ Phone Number: _____

Relationship to Consumer: _____

Reason they are no longer the Payee: _____

_____

Does the consumer have contact with family? ☐ Yes/Occasionally ☐ No *If yes/occasional, please complete the information below.*

Name of Relative: _____ Phone Number: _____

Relationship to Consumer: _____

Can this person serve as Payee? ☐ Yes ☐ No *If no, reason:* _____

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PSYCHIATRIC/DRUG & ALCOHOL INFORMATION

Primary MH Diagnosis: _____

Secondary MH Diagnosis: _____

Currently in Treatment? ☐ Yes ☐ No *If yes, please complete the information below.*

Agency: _____ Type of Service(s): _____

_____

Does the consumer *currently* use drugs/alcohol? ☐ Yes ☐ No ☐ History of Use

Currently in Treatment? ☐ Yes ☐ No *If yes, please complete the information below.*

Agency: _____ Type of Service(s): _____

_____

Does the consumer *currently* receive BCM services? ☐ Yes ☐ No

Name of BCM: _____ Phone Number: _____

Agency: _____

CONSUMER ACKNOWLEDGEMENT

It is understood by the referring agency and/or the consumer that the referred consumer may be placed on a waiting list until an opening with a Representative Payee becomes available.

_____ _____

Consumer Signature Date

_____ _____

Referral Signature *(if other than Consumer)* Date

The completed application along with a completed Authorization Notice and Social Security Administration Form 787 (also available online) can be submitted in person or sent by mail, email, or fax to:

Mental Health Association
140 N Elm Street
Butler, PA 16001
Attn: Jennifer Dearth

Email: jdearth@sphs.org | Fax: 724-287-7090

ALL APPLICATIONS, regardless of whether requesting a new payee or requesting a transfer of payee **MUST HAVE SSA Form 787** to process the application. No exceptions.