REPRESENTATIVE PAYEE PROGRAM REFERRAL

MENTAL HEALTH ASSOCIATION

140 NORTH ELM STREET, SUITE A

BUTLER, PA 16001

Phone: (724) 287 – 1965 Fax: (724) 287 – 7090

✳ All information on this form is considered confidential

Please complete all pages – fill in all blanks

Consumer Name: _____ Date: _____

Referral Source: _____ Self _____ Other (Please Specify) _____

RESIDENCE: STREET: _____ APARTMENT: _____

CITY: _____ STATE: _____ ZIPCODE: _____

Do you have an alternate mailing address? _____ Yes _____ No

Telephone: ( ) _____

How long have you been a resident of Butler County? _____

SOCIAL SECURITY NUMBER(s): _____ - _____ - _____

BIRTH DATE: _____ AGE: _____ SEX: _____ MALE ____ FEMALE

Marital Status

_____ MARRIED _____ SINGLE _____ DIVORCED _____ SEPARATED

_____ WIDOW / WIDOWER

SERVED IN MILITARY YES/ NO _____ Branch _____Years served

PAYEE STATUS:

Please describe the reason for request of payee services:

_____

_____

_____ There is a current payee

Name: _____ Telephone: ( ) _____

Relationship to consumer: _____

_____ This is a new payee request

Have you ever had Representative Payee Services before? _____ Yes _____ No

Has MHA of Butler County ever provided Payee services to you before? __ Yes __ No

Do you have a current guardian? ____ Yes _____ No

If yes, who?_____

Relationship to Consumer: _____

FAMILY INFORMATION:

Contact with family: _____ YES _____ NO _____ OCCASSIONALLY

Next of Kin: _____ Telephone: ( ) _____

Address:

_____

_____

Do you have a burial account set up or other burial arrangements made?

_____ Yes _____ No

Where? _____

PSYCHIATRIC / D & A – BACKGROUND INFORMATION:

Primary Diagnosis: _____

Secondary Diagnosis:_____

Are you currently in treatment? _____ Yes _____ No

If yes, with whom? _____

Are you open with case management services? _____ Yes _____ No

If yes please complete:

Case Manager Name	Agency	Phone Number

IT IS UNDERSTOOD BY THE REFERRING AGENCY and/ or CONSUMER:

The referred consumer may be placed on a waiting list until an opening with a representative payee becomes available

MAIL OR FAX TO:

Mental Health Association

140 North Elm Street

Butler, PA 16001

Attn: Mandy

FOR A NEW REQUEST INCLUDE DOUBLE – SIDED SSA DOCTOR'S PRESCRIPTION TO HAVE PAYEE COORDINATOR ALONG WITH THIS FORM

ALL REQUESTS REQUIRE A COPY OF SSA-787 TO PROCESS APPLICATION