Representative
Payee
Program

Please answer each question-do not leave blank!

Application Date: ______________

Name of person filling out application: ________________________ **Phone#:**______________________

Applicant Name: Last: ______________________ First: _______________________ Middle:________________

Social Security # _____-________-_________Birth Date: ___/___/______ Sex: Male Female

Physical Address: ____

Mailing Address: ____

Phone #____

Email Address: ____

Please provide answers to the following:

Marital Status: Single Married Divorced Widowed

If Married: Name of Spouse: ____

Address of Spouse: ____

Email Address of Spouse: ____

Do you live in a **group home**: YES NO

If you do **not** live in a group home, do you live alone: YES NO

If no, are the people living with your relatives? YES NO

Please write the names of the people you live with & their relationship to you:

____

____

Percentage of rent paid by each person living in the house: _____________________________

Name of Landlord: ________________________ Phone#: ____________________________________

Address:____

Amount of Rent:_____________ Amount of Utilities:___________ Other fees:________________

Case manager or Other Service Provider: ____

Name of Agency: ______________________________________Phone#: _________________________

Address of Agency: ____

Email Address: ____

*Are you on Medicaid? YES NO

If yes, what is your **Medicaid #**:____

Are you on a Medicaid Waiver Program? ____________________________________

*Are you on Medicare? YES NO

If yes, what is your **Medicare #**:____________________

Date of A:__________ Date of B:_________________

Any other insurance: Yes No

Name and Policy Number of other Insurance:

____

Are you signed up for **Food Stamps**? YES NO

Are you signed up for **LIEAP**? YES NO

<u>Please circle yes of no if you have the following:</u>

Checking Account YES NO Savings Account YES NO

A Special Needs Trust YES NO If yes, where: _________________________________

Funeral/Burial Plan YES NO If yes, where: _________________________________

Guardian or POA YES NO If yes, provide name, phone number & address:

____

Fathers Name:____________________ SS#_____________ DOB: ____________Date of Death:_______

Address: ____

Mother Name:____________________SS#_____________DOB:_____________Date of Death:________

Address: ____

Siblings/Friends Names & Addresses:

____

____

____

Emergency Contact Name & Relationship: ____

Phone#____

Address: ____