Catholic Social Services (CSS) welcomes the opportunity to serve you with our Payee Services. The list below details the required documents needed to process your application for service.

Please note that forms requiring an individual's signature, must be submitted as originally signed forms (no faxed, copied, or emailed forms will be accepted).

Did you submit the following documents? (Please check the box)

- ☐ **Copy of Social Security Card**
- ☐ **Photo ID**
- ☐ **New Client Questionnaire**
- ☐ **Consent for Service**
- ☐ **Release of Information**
- ☐ **Lease &/or Housing Voucher**
- ☐ _____
- ☐ _____

Please feel free to contact our office with any questions or concerns at 740-452-5057 (ext. 1) or 1-800-536-5057 (ext. 1).

CATHOLIC SOCIAL SERVICES

PAYEE SERVICES
NEW CLIENT QUESTIONNAIRE

Client's Name: _____

Alias/Nickname: _____

Date of Birth: _____ Social Security Number: _____

Client's Address: _____ Phone Number: (_____)_____

City: _____ State: ____ Zip Code: _____ County: _____

Race? (Optional) _____ Language(s) Spoken _____

Does the client currently have a Payee? **Y** **N** If yes, who? _____

Does the client have a Guardian? **Y** **N** _____ Person ____ Estate _____ Both

Guardian Name/Address/Phone #: _____

_____

INCOME INFORMATION

What is the client's income? _____ SS _____ SSI _____ WORK

_____ PENSION/RETIREMENT _____ OTHER: _____

If SS or SSI income, is it in suspense? _____

Does applicant receive/have any of the following:

_____ Medicaid _____ Food Stamps _____ Stocks/Bonds _____ Vehicles

_____ Life Insurance/Burial Policies _____ Trust Account _____ Bank Account

Does Applicant have any children? _____ Pay or receive Child Support? _____

Names & Birthdates of Children: (if received child support) _____

Employment History for the past 12 months (Please provide employer information, dates of employment, amount paid each month, & frequency of payment):

_____

_____

MARTIAL STATUS / HOUSING INFORMATION

_____ Single _____ Married _____ Divorced _____ Separated

Spouse Name: _____ Spouse Birthdate: _____

What is the client's current living arrangement?

_____ Lives Alone _____ Roommate(s) _____ With Family _____ Group Home _____ OTHER

Arrangement Info: _____

CURRENT RENT AMOUNT: $_____

Landlord Name, Address, & Phone #: _____

_____

CONTACT INFORMATION

Additional Contact Name (Does the client have a case worker, service coordinator, family member, or any other outside services that we could use as secondary contact?) **Y N**

Contact's Name, Agency, & Phone Number: _____

Where does the paperwork need to be sent (address, if different than clients)?

_____

Referral Source: _____ Self _____ Outside Agency/Other:_____

Additional Information: _____

_____

_____

_____

Office Use Only: Social Security Mail Date: _____

Direct Deposit Information (checking account):

Routing # _____ Account # _____

CATHOLIC SOCIAL SERVICES

PAYEE SERVICES
CONSENT FOR SERVICE

I, _____, request that Catholic Social Services provide payee services to assist me in the management of my financial situation.

I have the right to choose only those services I wish to receive and the intensity of the services.

I understand that if I have needs that cannot be met by the services provided by Catholic Social Services, my social worker will work with me to find more appropriate services.

I understand that I may discontinue services at any time with no repercussions from Catholic Social Services.

I understand that these services are provided to assist me in the management of my financial situation and I am solely responsible for any financial liability which may apply in this case.

Date: _____ Signature: _____

Date: _____ Witness Signature: _____

Catholic Social Services
PO Box 3446
Zanesville, OH 43702-3446

CATHOLIC SOCIAL SERVICES

PAYEE SERVICES

RELEASE OF INFORMATION

Client Name: _____ D.O.B.: _____

Social Security Number: _____

I hereby authorize Catholic Social Services to disclose, release and receive information contained in my client file (current and future documentation) to the listed authorized funders/providers that may assist me with my financial management needs. Any other inquiries must obtain a separate signed release of information.

I understand that my client records/health information (HIPPA) will be kept confidential and released only as need warrants. I also understand that I may revoke this authorization at any time by submitting in writing my decision to revoke.

Authorized funders/providers:

(Name)	(Address)
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

_____ _____

Client Signature Date Witness Signature Date