



CATHOLIC SOCIAL SERVICES

www.colscss.org

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**
- Guardianship Paperwork (If Applicable)**
- Bank Form and Verification (If Applicable)**

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).

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? _____

If yes, why do you want to switch payees? _____

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

Guardian Name/Address/Phone #: _____

Contact Information of Physician/Psychiatrist/Nurse Practitioner: _____

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 __ 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 # _____



**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: _____

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



**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 Individual/Agency:

(Name)

(Address & Phone Number)

Client Signature

Date



**PAYEE SERVICES
AUTHORIZATION FOR AUTOMATIC DEPOSITS**

I (we) hereby authorize Catholic Social Services to initiate credit entries to my (our) Checking or Savings (select one) indicated below at the depository financial institution named below, hereafter called DEPOSITORY, and to credit the same to such account. I (we) acknowledge that the origination of ACH transactions to my (our) account must comply with the provisions of U.S. Law.

FINANCIAL INSTITUTION INFORMATION

Bank/Institution Name: _____

Routing Number: _____ Account Number: _____

Checking/Savings - **Include a voided check for checking or a deposit slip for savings.**
(circle one)

This authorization is to remain in full force and effect until Catholic Social Services has received written notification from me (or either of us) of its termination in such time and in such manner as to afford Catholic Social Services and DEPOSITORY a reasonable opportunity to act on it.

Recipient Name(s): _____

Signature

Date

NOTE: Retain for at least 2 years after termination of last originated entry

Name: _____

Date: _____

Monthly Income:

Total Income:

Monthly Expenses

Amount

Note

Rent

Gas

Electric

Water

Trash

Telephone

Cable

Medical/Medicine

Food

Laundry

Spending

Client Fee

Total Expenses:

Surplus/Deficit:
