REPRESENTATIVE PAYEE PROGRAM REFERRAL

Mental Health Association
140 North Elm Street, Suite A
Butler, PA 16001
Phone: 724-287-1965 Fax: 724-287-7090

Please complete all pages – fill in all blanks. All information on this form is considered confidential.

Consumer Name: _____ Date: _____

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

Referral Phone: _____ Referral Email: _____

Residence

Street: _____ Apartment: _____

City: _____ State: _____ Zip Code: _____

Do you have an alternate mailing address? Yes / No

If yes, please list: _____

Phone: _____

How long has the consumer lived in Butler County? _____

Social Security Number: _____ - _____ - _____

Birth Date: _____ Age: _____ Gender: _____

Marital Status *(Please Circle)*

Single / Married / Separated / Divorced / Widow / Widower

Served in Military

Yes / No, Branch: _____ Years served: _____

Financial Information

Current monthly income: _____ Source: _____

Is there a current bank account? Yes / No, if yes:

Type: _____ Name of bank: _____

Payee Status

Please describe the reason for request of payee services:

_____

_____

Does the consumer currently have a payee? Yes / No, if yes:

Name of payee: _____ Phone: _____

Relationship to consumer: _____

Reason they can no longer serve as payee: _____

_____

Did the consumer have a payee in the past? Yes / No, if yes:

Name of payee: _____ Phone: _____

Relationship to consumer: _____

Reason they are no longer the payee: _____

_____

Does the consumer have a legal guardian? Yes / No, if yes:

Name of guardian: _____ Phone: _____

Relationship to consumer: _____

Can this person serve as payee? If no, explain: _____

_____

Does the consumer have contact with family? Yes / No / Occasionally, if yes or occasionally:

Name of relative: _____ Phone: _____

Relation to consumer: _____ Can this person serve as payee? Yes / No

If no, explain: _____

Psychiatric/Drug and Alcohol Information:

Primary MH Diagnosis: _____

Secondary MH Diagnosis: _____

Currently in treatment? Yes / No

Agency: _____ Type of service(s): _____

_____

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

Currently in treatment? Yes / No

Agency: _____ Type of service(s): _____

_____

Does the consumer currently receive BCM services? Yes / No, if yes:

Name of BCM: _____ Phone: _____

Agency: _____

***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.

The completed application can be mailed or faxed to:
Mental Health Association
140 North Elm Street
Butler, PA 16001
Attn: Mandy

Fax: 724-287-7090

For a new request, include the double-sided SSA doctor's prescription to have a payee coordinator along with this form. **ALL REQUESTS REQUIRE A COPY OF SSA-787 TO PROCESS APPLICATION.**