REPRESENTATIVE PAYEE PROGRAM SELF REFERRAL FORM

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 information

Consumer Name: _____ Date:_____

Referral Source: _____ Self _____Other: (Please Specifiy)_____

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:_____ - _____ - _____

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

Please check all that apply:

MARRIED _____ SINGLE _____ DIVORCED _____ SEPARATED _____

WIDOW / WIDOWER _____ SERVED IN MILITARY_____

PAYEE STATUS:

Please describe the reason for request of payee services:

_____

_____

_____ This is expected to be a short term service.

_____ This is expected to be a long term service.

_____ There is a current payee:

Name: _____ Telephone: ( ) _____

Relationship to consumer: _____

_____ This a new payee request

Have you ever had Representative Payee Services before? _____YES _____NO

Has MHA of Butler County ever provided Payees Services to you before? _____YES _____NO

Do you have a guardian? _____ YES _____ NO

Please list all individuals and/or programs you have asked to be your payee prior to contacting MHA of Butler County:

Name	Relationship	Contact Number

PSYCHIATRIC AND D & A 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 CONSUMER:

All referrals may be placed on a waiting list until an opening with a representative payee becomes available.

PLEASE MAIL OR FAX TO:

Mental Health Association

140 North Elm Street

Butler, PA 16001

Attn: Amanda Geibel

FOR ALL 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

For Internal Use Only:

Date application received:_____

Meets BCHS requirements for service: _____ Y or _____ N

Please list documentation or information still needed: