Representative Payee of the Piedmont
Referral & Intake Form

Date of Referral _____ Referred By:_____

Client Name _____ SS # _____

Address _____

City _____ Zip Code _____ County _____

Phone Number _____ DOB _____

Mother's Maiden Name_____ Place of Birth_____

Case Manager / Agency _____ Phone # _____

Legal Guardian yes no Name _____ Phone # _____

Current Payee Name _____ Phone # _____

Living Situation: Lives Alone _____ With Family _____ Homeless _____ Other _____

Race/Ethnicity _____ Medicaid – Y N Medicare - Y N

Client Disability – **(Circle all that apply)** DD MI Substance Abuse

Client Income SSI _____ SSDI _____ Other _____

Client Bills: **(Please include the company name, account number and an average amount)**

Rent _____
(Please include landlords name, address, phone & amount due monthly)

Utilities _____

Phone _____

Cable _____

Water _____

Gas _____

Other _____

Food Stamps - Yes No If yes, amount _____

Client History: _____

_____

Client Signature if Applicable_____ Date_____

Revised 4/2018

FAX TO: Rep Payee Intake
336-837-0815
Mail to: PO Box 11649, Winston Salem, NC 27116