

## 2-1-1 Payeeship Application

|  |   |
|--|---|
| First Name   | Last Name   |
| Address  | City/State/Zip  |
| SSN  | DOB   |
| Amount Received from SSA:<br><br>Do you currently have a Payee: Y / N                      | Did someone assist you in completing this application? Y / N<br>Name: |
|  |   |
| Are you currently receiving counseling services from a mental health provider?             | Y / N    Name of agency:<br><br>Name of case manager:                 |
| Are you currently receiving counseling services from an agency for alcohol or drug issues? | Y / N    Name of agency:<br><br>Name of case manager:                 |
| Are you a client of the Fairfield County Board of Developmental Disabilities (DD)          | Y / N    Name of ISC:   |
| Are you on probation or parole?  | Y / N    County:<br><br>PO Name:<br><br>Court fines owed? _____/month |
| Current Landlord:  | Landlord Address:   |
|  |   |
| TOTAL INCOME:  | SOURCES OF ALL INCOME:<br>_____<br>_____<br>_____<br>_____            |
| Family Physician<br>Name:<br><br>Phone:  | Psychiatric Doctor or Nurse:<br>Name:<br><br>Phone                    |

| EXPENSE                      | AMOUNT | Due Date | Last Paid |
|------------------------------|--------|----------|-----------|
| Rent or Mortgage             |        |          |           |
| Rent/Homeowner Insurance     |        |          |           |
| Electric                     |        |          |           |
| Household Gas                |        |          |           |
| Water/Sewer/Trash            |        |          |           |
| Home Phone                   |        |          |           |
| Cell Phone                   |        |          |           |
| Grocery (out-of-pocket)      |        |          |           |
| Cable Television / Satellite |        |          |           |
| Internet Services            |        |          |           |
| Vehicle Payment              |        |          |           |
| Auto Insurance               |        |          |           |
| Gasoline                     |        |          |           |
| Auto Maintenance             |        |          |           |
| Doctor Visits                |        |          |           |
| Health Insurance             |        |          |           |
| Prescriptions                |        |          |           |
| Medical Bills                |        |          |           |
| Childcare                    |        |          |           |
| Child Support                |        |          |           |
| Credit Cards                 |        |          |           |
| Laundry                      |        |          |           |
| Legal fees / Court fines     |        |          |           |
| Other                        |        |          |           |
| Other                        |        |          |           |

By signing below, I confirm that all of the information in this application is correct. I give permission to Fairfield County 2-1-1 to contact any business or agency in regard to my accounts, expenses, or payments.

---

Client Signature

Phone

Date

---

Agency Representative

Agency Name / Phone

Date

|                |            |                 |
|----------------|------------|-----------------|
| Date Received: | Signature: | SSA787<br>SSA11 |
|----------------|------------|-----------------|