2-1-1 Payeeship Application

First Name	Last Name
Address	City/State/Zip
SSN	DOB
Amount Received from SSA	Did someone assist you in completing this application? Y / N Name:
Are you currently receiving counseling services from a mental health provider?	Y / N Name of agency: Name of case manager:
Are you currently receiving counseling services from an agency for alcohol or drug issues?	Y / N Name of agency: Name of case manager:
Are you on probation or parole?	Y / N County: PO Name: Court fines owed? _____/month
Current Landlord:	Landlord Address:
TOTAL INCOME:	SOURCES OF ALL INCOME: _____ _____ _____ _____
Family Physician Name: Phone:	**Psychiatric Doctor or Nurse:** Name: Phone

EXPENSE	AMOUNT	Due Date	Last Paid
Rent or Mortgage			
Rent/Homeowner Insurance			
Elecrtic			
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 SSA11