2-1-1 Payee Application

Client Name	Client Phone Number	
Address	City/State/Zip	
Social Security Number	Date of Bir	rth
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 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:
		PO Name:
		Court fines owed?/month
Current Landlord:	Landlord Address:	
Do you have a legal guardian?	Y/N	Guardian Name:
		Address:
		Phono:
		Phone:
Family Physician	Psychiatric	c Doctor or Nurse:
Name:	Name:	
Phone:	Phone	
Total Income:	List all sou	irces of income:
Total intollie.	List all sou	nees of meome.

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			
	1	1	l .

Client Signature			Date
Agency Representative	Agency Name / Phone		Date
Date Received:	Signature:	SSA787	
		SSA11	

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.