



**BILL PAYER PROGRAM
CLIENT REFERRAL FORM**



Send to: **CSCS Bill Payer Program**
195 Montague Street, Suite B-15
New York NY 11201

FAX: 718-858-2702
Phone: 718-858-2360
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All information disclosed on this referral is confidential

Client Information

Referral Date: ____/____/_____
Client Name _____
Address _____
City _____ State _____ Zip _____
Phone _____ E-mail _____
DOB _____ Ethnicity _____ Gender: M F
Primary language: English Other (specify) _____

Living Situation

Live alone? Yes No # in household & relationship (s) _____
 Homebound Smoke Dog Cat Other Pet _____
 Doorman Elevator Buzzer System Stairs If stairs, # of flights _____
Other building info _____
Building maintenance: Excellent Good Fair Poor
Apartment condition: Excellent Good Fair Poor

Eligibility

Are client's liquid assets under \$40,000? Yes No
Does client understand and agree to this referral? Yes No
Is client able to make his/her own financial decisions? Yes No
Is client able to sign his/her own checks? Yes No
If "no" above, please explain: _____
How is client paying clients bills now? _____
Is gender, language, or any other volunteer characteristic important to this client? Yes No
If "yes," state preference _____

Emergency Contact

Name _____ Relationship _____
Address _____
City _____ State _____ Zip _____
Phone _____ Email _____

Referral Source

Name _____
Agency _____
Address _____
City _____ State _____ Zip _____
Phone _____ E-mail _____
Relationship to client _____
Indicate if your services to this client are: Long Term Short Term

Referral Information

Why is the client being referred for services? Please check all that apply.

- Visually impaired
- Hearing Impaired
- Physical disability _____
- Mental Illness _____
- Developmental Disability
- Memory loss or confusion
- Overwhelmed/Nervous about bills
- Needs help reading/writing
- Needs help budgeting
- Bounced checks/overdrafts
- Unpaid bills
- Paperwork piling up
- Loss of prior bill payer
- Utility shut-off notices
- Threat of eviction
- Insufficient money at month's end
- Financial Abuse
- Worrisome debt estimated at _____

Does the client have mental illness, substance abuse, communication or behavior issues that might affect the relationship with the volunteer? Yes No

If yes, please describe: _____

Does client have memory loss? No Mild Moderate Severe

Describe any other issues, concerns or special circumstances relevant to this referral:

Other Services

What other services are currently being provided for this client?

- Shopping
- Escort
- MH Counseling
- Meals-on-Wheels
- Transportation
- Case Assistance
- Case Management
- Day program
- Home Care: specify hours/days _____

Financial Information

Monthly income sources and amounts: SSA \$ _____ SSI \$ _____

SSD \$ _____ Pension \$ _____ Other (specify) \$ _____

TOTAL MONTHLY INCOME: \$ _____ MONTHLY RENT (or maint/mortgage) \$ _____

Check if client has: Power of Attorney Representative Payee Guardian

If yes, name of designee: _____

Check if client receives: SSI Medicaid Food Stamps (amount) \$ _____

Foundation stipend Pooled-income trust (e.g. NYSARC)

Banking Information

Check if client has: Checking account Direct Deposit Savings account

Automatic Bill Payments (specify bills on auto-pay) _____

Name of bank _____

Does client receive cancelled checks/check images with the bank statement? Yes No

THANK YOU!

A Bill Payer Program staff member will contact you before calling this client.