



**BILL PAYER PROGRAM
CLIENT REFERRAL FORM**



Send to: **Council of Senior Centers and Services of NYC, Inc.**
49 W. 45th Street, 7th Floor
New York NY 10036

FAX: 212-398-8398
Phone: 212-398-6565 x 230

The AARP Foundation Money Management Program provides volunteer Bill Payers who help clients organize bill paying and related record keeping. Clients maintain control over all financial decisions. *Clients always sign their own checks.* This referral is for bill-paying services only.
All information disclosed on this referral is confidential

Referral Source

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

Client Information

Name _____
Address _____
City _____ State _____ Zip _____
Phone _____ E-mail _____
DOB _____ Ethnicity _____ Gender: M F
Primary language: English Other (specify) _____
Emergency Contact _____ Relationship _____
Address _____
City _____ State _____ Zip _____
Phone _____ Email _____
Physician Name _____ Physician Phone _____

 Medicare A Medicare B Medicaid Medigap Other _____

Financial Information

Client's annual income before taxes: < \$10,000 \$10,000-\$20,000
 \$20,001-\$30,000 \$30,001-\$40,000 \$40,001-\$49,000

Monthly income sources and amounts: SSA \$ _____ SSI \$ _____
Pension \$ _____ Other (specify) _____ \$ _____

Are client's liquid assets under \$35,000? Yes No Don't Know

Living Situation

Does client live alone? Yes No If no, number in household _____
Relationship(s) to client _____
 Homebound Visually impaired Hearing Impaired Smoke
Pets: Dog Cat Other _____

Doorman Elevator Buzzer System Stairs Number of flights _____
 Other building info _____
 Building maintenance: Excellent Good Fair Poor
 Apartment condition: Excellent Good Fair Poor
 Superintendent's Name: _____ Tel: _____

Client Status Questions

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

If yes, please describe: _____

2. Does client have significant memory loss? Yes No

3. Is gender, language, or any other volunteer characteristic important to this client? Yes No
 If yes, state preference _____

4. Does client understand and agree to this referral? Yes No

If no, please explain _____

5. Have any of the following arrangements been made for the client?

Power of Attorney Representative Payee Guardian

If yes, provide name, address and phone of designee: _____

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

- | | |
|--|---|
| <input type="checkbox"/> Physical disability affecting bill paying | <input type="checkbox"/> Bills not paid |
| <input type="checkbox"/> Mental disability affecting bill paying | <input type="checkbox"/> Paperwork piling up |
| <input type="checkbox"/> Loss of prior bill payer | <input type="checkbox"/> Needs assistance reading & writing |
| <input type="checkbox"/> Memory loss or confusion | <input type="checkbox"/> Overwhelmed or nervous about bills |
| <input type="checkbox"/> Financial exploitation | <input type="checkbox"/> Utility shut-off notices |
| <input type="checkbox"/> Bouncing checks | <input type="checkbox"/> Insufficient food/money at month's end |
| <input type="checkbox"/> Worrisome debt estimated at | <input type="checkbox"/> Threat of eviction |
| \$ _____ | <input type="checkbox"/> Other _____ |

7. How is client paying bills now? _____

8. Does client have the following? Check all that apply:

Checking account Direct Deposit Savings account Automatic Bill Payments

Specify any bills on auto-pay: _____

Name and address of bank branch _____

9. What other formal or informal services are currently being provided for this client?

Home Care Escort Shopping Meals-on-Wheels
 Transportation Case Assistance Case Management

10. Please describe other needs/concerns _____
