THE CORPORATION OF
GUARDIANSHIP

REPRESENTATIVE PAYEE INTAKE FORM

Please complete the following forms – Representative Payee Intake Form; Representative Payee Budget Form; and Representative Payee Authorization Form (signature required). The completed forms can be faxed to 336-275-8879 or mailed to 122 N. Elm Street Suite 601, Greensboro, NC 27401. Please note that the Corporation of Guardianship charges a monthly fee to provide Representative Payee services. The client will receive all funds by mail and may not pick up funds in person. Please contact us at 336-273-5389 if you need further information.

Client Name: ____
(First) (Middle) (Last)

Street Address: ____
(Street) (City) (State/Zip) (County)

Telephone Number: ____
(Home) (Cell) (Other)

Social Security Number: ________ - ________ - ________ Date of Birth: __________ Place of Birth: _________________

Client's Mother's Maiden Name: ____________________ Client's Father's First Name: ______________________

Marital Status: ☐ Single ☐ Married (Spouse's Name: ______________) ☐ Separated ☐ Divorced ☐ Widowed

Living Arrangement: ☐ Independent ☐ Adult Care Home ☐ Intermediate Care Facility ☐ Skilled Nursing Facility

List Other Persons Living in Household by Name & Relationship: ____

Prior Payee, if any (Name/Agency/Contact Information): ____

Social Security Benefits (Check all that apply and list benefit amount):

_____ Social Security Disability Monthly Amount: $__________
_____ Social Security Retirement Monthly Amount: $__________
_____ Supplemental Security Income Monthly Amount: $__________

Is Client drawing benefits based on someone else's work record? ☐ Yes ☐ No

Name: ____

SSN: _________________________ Relationship to Client: ________________________________

Does the Client have a Legal Guardian? ☐ Yes ☐ No ***If yes, please provide certified copy of Guardianship Letters and signed SSA form 4164***.

Guardian Name: ____

Guardian Street Address: ____

Guardian Phone Number: ___________________________ Email: ____________________________________

Guardianship County: ________________________________ File Number: ___________________________

Is Client currently employed? ☐ Yes ☐ No

Place of Employment: ____

Contact Person to Verify Monthly Paystubs: ____

Telephone Number: ___________________________ Email: _______________________________________

What is the **PRIMARY** nature of the client's disability?

☐ Brain/Head Injury
☐ Cerebral Palsy
☐ Autism
☐ Intellectual/Dev. Disability
☐ Mental Illness
☐ Substance Abuse/Addiction
☐ Multiple Sclerosis
☐ Spinal Cord Injury
☐ Dementia/Alzheimer's Disease
☐ Other - Specify:________________

Please provide a brief description of the reason why this individual needs a Representative Payee:
____
____

Referred by (Name/Agency/Contact Information): ____

EXPENSES INFORMATION

Please list ROUTINE bills and expenses below, including personal funds. Please indicate if personal funds are to be sent once per month or twice per month.

Creditor/Vendor & Account Number	Contact Information	Contact Information
EXAMPLE: *Duke Energy* *Acct. # 123-456-789*	*EXAMPLE:* *345 Any Street* *Any Town, NC 12345* *(555) 555-5555*	*EXAMPLE:* *345 Any Street* *Any Town, NC 12345* *(555) 555-5555*