BRAZOS BEND GUARDIANSHIP SERVICES

Client Referral

Our Representative Payee Money Management Program best benefits low income mentally disabled adults who are starting to lose or do not have the cognitive ability to manage their monthly income and bills are not being paid which puts them at risk of losing their independence. Someone showing early signs of dementia, someone with a mental health issue, someone that has had a stroke or brain injury or someone with an intellectual developmental disability is more the type of individual that will benefit from the way our Representative Payee Money Management Program is structured to work. This program is accomplished by using screened Staff and or VOLUNTEERS to serve as Representative Payees. Brazos Bend Guardianship Services is the agency providing the program in the Ft. Bend County area. All volunteers are trained and monitored.

Representative Payees help the clients to manage the government benefit (Social Security, Supplemental Security Income, Dept. of Veterans Affairs, Railroad Retirement, Office of Personnel Management) they are receiving by developing a budget, balancing their check book and paying bills. BBGS will have check signing authority.

If you know someone that could possibly benefit from this program and they meet the qualifications below, please complete the attached referral and send it to Kirk Monroe via fax (281-310-8700) or by mail to: PO Box 72, Rosenberg, TX. 77471. Also, contact Kirk at 281-232-7701 if you have any additional questions.

Money Management Client Qualifications:

Be a resident of Ft. Bend County

Annual income can be no greater than $25,000.

Be willing to accept assistance and be supportive of Brazos Bend Guardianship Services being named as organizational representative payee.

Client must be non-violent and non-abusive

Client cannot have a history of running away

Client **MUST** have 2 Forms of ID (a government issued ID and SS Card)-the bank requires this to be able to open a checking account.

Client's health and/or living conditions cannot pose a risk to BBGS Staff or volunteers.

Be able to provide a letter from the client's Dr. that they are not able to manage their income.

Local Site Name: Brazos Bend Guardianship Services
Date _____

Client Referral Form
Fax completed form to Brazos Bend Guardianship Services at 281-310-8700

Brazos Bend Guardianship Services' Money Management Program is offered as a Representative Payee Program. The Representative Payee client cannot handle funds and make financial decisions; BBGS can only be appointed as Organizational Representative Payees for federal benefits from these agencies: Social Security Administration, Department of Veteran Affairs, Railroad Retirement Board, or Office of Personal Management.
Other sources of client income or savings cannot be managed by Brazos Bend Guardianship Services staff or volunteers.

All information disclosed on this referral is confidential

Client Identification

Name:_____
Address:_____
_____
Phone Number :_____
Date of Birth: _____
Social Security Number:_____-_____-_____
Sex of Client: ☐Male ☐Female

Client Communication Skills
Speaks English: ☐ Well ☐ Poorly ☐ Not at all
Primary language_____

Referral Source
Name:_____
Agency_____
Address_____
_____
Email_____

Relationship of referrer to client:
_____
Does client have a case manager? If so, provide name and phone number_____

Client Income

Total monthly income $_____
Income sources and amounts
SSA $_____ SSI $_____
Other_____$_____
Other_____$_____

Emergency Contact
Name:_____
Address:_____
_____
Phone # _____
Email _____
Relationship to client _____
Physician_____
Phone #_____
Hospital used_____

Living Information

Does client live alone? _____
If no, how many in household?_____
Are others in household related to client?
_____

Can they help the volunteer? _____

Is the client mostly homebound?_____

Client's name_____

Client Status Questions

1. Why was the client referred for services? Check all that apply.

- ☐ Physical disability affecting bill paying
- ☐ Mental disability affecting bill paying
- ☐ Bills not paid
- ☐ Loss of prior bill payer
- ☐ Memory loss or confusion
- ☐ Financial Exploitation
- ☐ Bouncing checks
- ☐ Worrisome debt estimated at $_____
- ☐ Paperwork piling up
- ☐ Needs assistance reading & writing
- ☐ Overwhelmed or nervous about bills
- ☐ Utility shut-off notices
- ☐ Insufficient food/money at month's end
- ☐ Threat of eviction
- ☐ Other_____

2. Are there any behavioral or emotional problems that could make the client inappropriate for volunteer assistance? If so, describe_____

_____

3. In the past 2 years has the client received help from a social worker, psychologist, doctor or other mental health professional for stress, addictions or an emotional or nervous problem? If so, describe:_____

_____

4. Would the gender of the volunteer be important to the success of this match?_____
5. Is this client covered by the following? Check all that apply

☐ Medicare part A ☐ Medicare part B ☐ Medicaid ☐ Medigap Policy

☐ Other health insurance? If so, describe_____

6. Have any of the following protective arrangements been granted in support of the client?

☐ Guardian ☐ Conservator ☐ Power of Attorney ☐ Representative Payee

If so, please provide name, address, phone number of fiduciary _____

_____

7. How is the client paying bills now?_____
8. Have you discussed the program with the client?_____ Is s/he agreeable to it?_____
9. Is the client capable of understanding why s/he is being referred?_____
10. Does the client have significant memory loss?_____
11. Does the client ☐ smoke? ☐ have pets (type:_____)?
12. Are there any other immediate concerns you have regarding this client?_____

_____

_____

Client Name_____

13. Does the client have the following? Check all that apply.

☐ Checking account ☐ Direct deposit ☐ Savings account

14. To the best of your knowledge, is the client's annual income $25,000 or less?

☐ Yes ☐ No ☐ Don't know

15. Does the client have a will? ☐ Yes ☐ No ☐ Don't know
If not, provide contact information for nearest relative_____

_____

16. How is the client currently purchasing groceries and other personal needs items?_____

_____

17. What other formal or informal services are currently being provided to the client?

☐ Homemaker ☐ Personal Care ☐ Shopping ☐ Meal assistance ☐ Transportation

☐ Other _____

18. What other services are needed?_____ __

_____

19. Does the client have a valid ID or Drivers License? N _____ Y_____

20. Does the client have a Social Security Card? N_____ Y_____

21. Name and contact info. of Dr. that will be providing letter stating the client is unable to manage their money

Dr:_____

Work phone:_____

Address:_____ City:_____ Zip_____

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