

**AARP Foundation Money Management Program**

Local Site Name: The Arc of Fort Bend County

Date \_\_\_\_\_

**Client Referral Form**

**Fax completed form to The Arc of Fort Bend County at 281-499-5976**

The AARP Foundation Money Management Program is delivered in three ways: Money management information to help educate individuals and their caregivers; and through our volunteers, a Bill Payer Program and a Representative Payee Program.

The Bill Payer client maintains control over all decisions about his or her funds. He or she only needs help keeping affairs organized and/or writing checks. The client always signs the check.

The Representative Payee client cannot handle funds and make financial decisions; the volunteer appointed to serve as the client's payee manages federal benefits on behalf of the client. Volunteers can only be appointed to be Representative Payees for federal benefits from their agencies: Social Security Administration, Department of Veteran Affairs, Railroad Retirement Board, or Office of Personal Management. If the Representative payee client has a source of non-federal income, such as a private pension, only Bill Payer services are available for that portion of the client's income.

*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.

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

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 income within guidelines and liquid assets below \$30,000?    Yes    No    Don't know

15. Does the client have a will?    Yes    No

If not, provide contact information for nearest relative \_\_\_\_\_  
\_\_\_\_\_

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

Homemaker    Personal Care    Shopping    Meal assistance    Transportation

Other \_\_\_\_\_

17. What other services are needed? \_\_\_\_\_  
\_\_\_\_\_

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Contact Kirk Monroe if you have any questions at 281-499-2234