

Thompson Social Services, Inc.

39 S. Tulpehocken St. Pine Grove, PA 17963/(570) 617-4944
313 W. Liberty St. Suite 203 Lancaster, Pa 17603

Demographics

Date of Request: _____/_____/_____

Name: _____

LIST ANY OTHER NAMES YOU USED IN PAST 10 YEARS: _____

Address: (No P.O. Box) _____

County of Residence: _____

Place of Birth (City/State/Country) _____

Are you a US Citizen? _____ Yes _____ No If No, Status: _____

Social Security Number: _____ - _____ - _____ Date of Birth: _____/_____/_____

Home Number:(_____) _____ - _____ Cell Number:(_____) _____ - _____

What is the reason you receive SSI/SSDI (What is your medical diagnosis or disability?)

What is the reason you are unable to manage your own finances?

Next of Kin:

Mother's Maiden Name: _____

Name: _____ Relationship: _____

Address: _____

Phone #: (_____) _____ - _____

Married: _____ Yes _____ No

Children: _____ Yes _____ No Number: _____

Reside with: (check one)

- Alone Personal Care Boarding Home
 Relative/Friend Facility
 Group Home/CLA Other _____

(Please list names and relationships of persons living with you)

Name	Relationship
1) _____	_____
2) _____	_____
3) _____	_____
4) _____	_____
5) _____	_____

(Attach additional sheets if more space is needed.)

Sources of Income and monthly amounts:

SSD \$ _____ SSI \$ _____ VA \$ _____ Payroll/Other \$ _____

Are you employed? _____ Yes _____ No

If yes, please complete the following:

Employer Name: _____

Employer Address: _____

Hours worked per week: _____ Days per week? _____ Rate of pay: _____

ASSETS/Banking Information (PROVIDE MOST RECENT STATEMENT)

Please list any checking/savings accounts on which your name appears:

Bank: _____

Type of Account: _____ Account Number: _____

Bank: _____

Type of Account: _____ Account Number: _____

Do you have a burial account? _____ Yes (PROVIDE COPY) _____ No

If yes, Bank Name: _____ Account #: _____

Do you have a burial plot? _____ Yes (PROVIDE COPY) _____ No

If yes, where? _____

Do you have a Life Insurance Policy? _____ Yes (PROVIDE COPY) _____ No

If yes, Insurance Co. Name: _____

Policy #: _____ Value: \$ _____

Health Insurance

Medical Assistance? _____ Yes _____ No

ACCESS #: _____

Medicare? _____ Yes _____ No

Part A Claim #: _____ Effective Date: _____

Part B Claim #: _____ Effective Date: _____

Any Other Insurance? _____ Yes _____ No

Name: _____

Current Servicers

Does the Client have a court appointed legal guardian? _____ Yes _____ No

If yes, please provide Name and Address and a copy of the Court Appointment:

Does the Client currently have a representative payee? _____ Yes _____ No

If yes, please explain why this change is being requested.

Case Manager: _____

Agency Name & Address: _____

Phone#:(_____)_____-_____ Email:_____

**PLEASE PROVIDE A COPY OF EACH OF THE FOLLOWING
FOUR DOCUMENTS:**

1. A State ID or Driver's License
2. Medical Insurance Card(s)
3. Social Security Card
4. Birth Certificate, Valid Passport, Certificate of
Citizenship or Naturalization

YOUR BUDGET

You are responsible for having all your bills sent directly to:

Thompson Social Services, Inc.

39 S. Tulpehocken St.

Pine Grove, Pa 17963

Bills that are not sent directly to TSS cannot be guaranteed for payment by due date.

**List all your monthly bills and current amounts due below and send us a signed copy
of your current lease. (Attach additional sheets as needed.)**

***CALL YOUR ELECTRIC/GAS/TRASH/ETC PROVIDERS AND
HAVE ALL BILLS SENT DIRECTLY TO:**

THOMPSON SOCIAL SERVICES, INC.

39 S. TULPEHOCKEN ST.

PINE GROVE, PA 17963

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AUTHORIZATION FOR RELEASE AND RECEIPT OF INFORMATION

I give permission for Thompson Social Services to communicate relevant information with the Social Security Administration, financial institutions, mental health/residential staff or other appropriate resources working and on behalf of me. That permission will remain in effect during the time that Thompson Social Services, Inc. is holding my funds.

(Client Signature)

(Date)

(Witness Signature)

(Date)

REQUEST FOR REPRESENTATIVE PAYEE SERVICES

I am requesting that Thompson Social Services, Inc. serve as Representative Payee for my Social Security/ Supplemental Security/Veteran's Benefits. I understand that my benefits will be deposited into a checking account and that I will not have direct access to the funds.

I understand that there is a fee for this service in accordance with Social Security Administration rules and regulations.

(Client Signature)

(Date)

(Witness Signature)

(Date)