VOICES OF INSPIRATION NORTH
NEW CLIENT PERSONAL INFORMATION FORM

PERSONAL INFORMATION:

NAME: ________________________________ **SSN:** ______/ __________/ __________

DATE OF BIRTH: ____________________ AGE: ______________

PLACE OF BIRTH:
(City & State)

MARITAL STATUS: Married _____Divorced _______ Separated_______ Single__________
X Widowed _____

IF MARRIED:
SPOUSES NAME:____SPOUSE'S AGE:__________

SPOUSES SSN: __________ __

CURRENT HOUSING/LIVING ARRANGEMENTS:

I LIVE IN A: House________Apt_________ Room in A Private Home________ Room & Board________
Board & Care Facility________Motel/Hotel_________ Mobile Home________ I Am Homeless ________

CURRENT ADDRESS: ____APT #: __________
CITY/STATE/ZIP: ____
PHONE NUMBER: ____

HOW LONG HAVE YOU LIVED AT YOUR CURRENT ADDRESS: ____________ ____________
Since (Month) (Year)

HOW MUCH IS YOUR MONTHLY RENT/ROOM & BOARD/Board & CARE: $________________

NAME OF LANDLORD: ____
LANDLORD'S ADDRESS: ____
____

LANDLORD'S PHONE NUMBER: ____

ARE YOU RELATED TO THE LANDLORD/ROOM& BOARD/BOARD & CARE PROVIDER: Yes_______No______

IF YES, WHAT IS RELATIONSHIP: ____

CURRENT HOUSEHOLD COMPOSITION:

I LIVE (WITH) Alone_______Children_________Spouse_________Parent(s)________
With A Relative________ Others________

DO YOU HAVE ANY DEPENDENT CHILD(REN) WHO CURRENTLY LIVE WITH YOU:

Yes________ No________

IF YOU HAVE DEPENDENT CHILD(REN) WHO LIVE WITH YOU, LIST NAMES, AGES & SSN'S FOR ALL DEPENDENT CHILDREN WHO LIVE WITH YOU:

NAME____________________________ DATE OF BIRTH_______________AGE________SSN:____________________
NAME____________________________ DATE OF BIRTH_______________AGE________SSN:____________________
NAME____________________________ DATE OF BIRTH_______________AGE________SSN:____________________
NAME____________________________ DATE OF BIRTH_______________AGE________SSN:____________________
NAME____________________________ DATE OF BIRTH_______________AGE________SSN:____________________
NAME____________________________ DATE OF BIRTH_______________AGE________SSN: ____________________

DO ANY OF YOUR DEPENDENT CHILD(REN) RECEIVE:
AFDC/TANF_____SSA_____SSI_____VA Pension_______

IF YOU LIVE WITH A RELATIVE OR FRIEND, LIST NAME OF ALL RELATIVES & FRIENDS:

NAME:______________________________________RELATIONSHIP:_____________________________
NAME:______________________________________RELATIONSHIP:_____________________________
NAME:______________________________________RELATIONSHIP:_____________________________
NAME:______________________________________RELATIONSHIP: _____________________________

DO ANY OF YOUR RELATIVES/FRIENDS, WHO YOU LIVE WITH, RECEIVE: AFDC/TANF_____
SSA_____SSI_____VA Pension_______

DO YOU EXPECT YOUR LIVING ARRANGEMENTS OR HOUSEHOLD COMPOSITION TO CHANGE:

YES_______NO________

IF YES, PLEASE EXPLAIN :____
____

INCARCERATION/HOSPITALIZATION:

HAVE YOU BEEN INCARCERATED (IN JAIL) MORE THAN 30 DAYS DURING THE LAST 12 MONTHS?:

YES________NO___________

IF YES: EXPLAIN ____

HAVE YOU BEEN HOSPITALIZED MORE THAN 30 DAYS DURING THE LAST 12 MONTHS? YES________NO __________

IF YES: EXPLAIN ____

CURRENT BENEFITS & PAYEE STATUS

HAVE YOU RECEIVED A NOTICE FROM SOCIAL SECURITY THAT YOU OWE AN OVERPAYMENT? Yes_______No_______

IF YES: EXPLAIN ____

DO YOU CURRENTLY HAVE A PAYEE: Yes__________No _________

NAME OF PAYEE: ____

PAYEE ADDRESS: ____

PAYEE PHONE #: ____

WHY DO YOU WANT TO CHANGE FROM YOUR CURRENT PAYEE? ____________________________

____

EMERGENCY CONTACTS: To be used as an alternate contact to reach you in an emergency

NAME:____ RELATIONSHIP: ________________________

ADDRESS:____

CITY/STATE/ZIP:____

PHONE: ____

NAME: ____ RELATIONSHIP: _______________________

ADDRESS:____

CITY/STATE/ZIP:____

PHONE: ____

CURRENT CASEWORKER/SOCIAL WORKER: To be used for emergency contact to reach in-home supportive service staff, mental health, and or drug & alcohol treatment & counselors

NAME: ____

ORGANIZATION:____

ADDRESS:____

PHONE: ____

DESIGNATED BENEFICIARY: In the case of your death, list the individual(s) whom you would name as the beneficiary to any funds you are entitled to and have on account.

NAME:_______________________________________RELATIONSHIP:____________________

ADDRESS: ____

CITY/STATE/ZIP: ____

PHONE NUMBER: ____

RELATIONSHIP TO YOU: ____

******************** CHANGES THAT MUST BE REPORTED TO VOIN *********************

I understand that certain circumstances can affect my eligibility for benefits and the amount of those benefits. I understand **I must report any of the following**:

- I get a job or stop working
- I move
- I get married
- I get money from another source
- I take a trip outside the United States
- I go to jail or prison
- I am admitted to a hospital
- I save any money
- I apply for assistance from a welfare agency or other government source
- I am no longer disabled

FEE FOR SERVICE ACKNOWLEDGEMENT:

I___________________________________understand that Voices of Inspiration North (VOIN) Payee Service charges a monthly fee of 10% of my benefit not to exceed $43 per month for management of my SSI/SSA benifits.

_____________________________________ _________________________

CLEINT SIGNATURE DATE

In event the above beneficiary has marked their signature by “X”, a Witness Signature is required

_____________________________________ _________________________

WITNESS SIGNATURE DATE