

SECURE BENEFIT SERVICES, INC

P.O BOX 60 ST. PETERSBURG, FL 33731

CLIENT INFORMATION SHEET

Date: _____

Referral Agency: _____ Case Mgr: _____ Phone: _____ Fax: _____

Client Name: _____ Social Security Number: _____

Home Phone #: _____ Cell Phone#: _____ Fax#: _____

Address: _____ City/State/Zip: _____

PO Box: _____ City/State/Zip: _____ Send Mail To: Home / PO Box / Other _____

DOB: _____ Place of Birth: _____ Mothers Maiden Name: _____

Emergency Contact: _____ Phone#: _____ Current Payee: Yes / No

If No Current Payee the "Physician's/Medical Officer's Statement of Patient's Capability to Manage Benefits" needs to be completed

Doctors Name: _____ Phone#: _____ Fax#: _____

Do you live alone? YES / NO If NO how many people are in your household? _____ What portion of living expenses do you pay? _____

Date you moved to your current address: _____

FINANCIAL INFORMATION

Income: SSI \$ _____ SSDI \$ _____ RETIREMENT/CHILD \$ _____ SURVIVORS/CHILD \$ _____

OTHER INCOME: \$ _____ SSA PAYMENT CYCLE/PLEASE CIRCLE: 1, 2, 3, 4

Expenses:

Rent/Room & Board: \$ _____

Power Co. _____ \$ _____

Phone Co. _____ \$ _____

Cable Co. _____ \$ _____

Sewer/Water Co. _____ \$ _____

Other: _____ \$ _____

Landlord Information:

Payable To: _____

Address: _____

City/State/Zip: _____

Contact: _____ Phone#: _____ Fax#: _____

Monthly Grocery Card: YES / NO Amount: \$ _____

Circle One: Publix / Sweetbay / Winn Dixie / Wal-Mart

MEDICARE/MEDICAID

State Funded Medicare premium: YES / NO Medicare #: Part A: _____ Effective Date: _____

Part B: _____ Effective Date: _____

Food stamps: YES / NO Prescription Cost: _____ Insurance Carrier: _____

Notes: