Payee Program Client Face Sheet

Family and Payee Counseling Service

1475 Terminal Way Ste B Reno NV 89502

Telephone: 775-322-6557 Fax: 775-322-6930 Toll Free: 1800-275-0137

All information held strictly confidential

Last Name:_____ First Name:_____ Date:_____

Address:_____ SSN:_____

City:_____State:_____ Zip:_____ DOB:_____

Mother's Maiden Name_____ POB:_____

Emergency Contact Name:_____Relationship:_____Phone:_____

Case Worker / Social Worker Information

Name:_____ Agency_____

Address:_____ Phone: _____

City:_____ State:_____ Zip:_____

Income Information

SSI _____ SSD _____ VA_____ Pension_____ Child support _____

TANF/Food Stamps_____ Other _____

Housing Information

Landlord: _____ Amount:_____Phone:_____

Address:_____City:_____State:_____Zip:_____

Necessary Expenses Paid by FCS

	Vendor
Power:	_____
Gas:	_____
Water:	_____
Telephone:	_____

Miscellaneous Expenses Paid by FCS

Vendor

_____

_____

_____

_____

Allocations of remaining funds

	Frequency	Amount
Food:	_____	_____
Pers. Use:	_____	_____

Client Notes:

OMB Approved No. 2900-0564
Respondent Burden: 15 Minutes
Expiration Date: 02/28/2019

Department of Veterans Affairs

VA DATE STAMP
(DO NOT WRITE IN THIS SPACE)

DIRECT DEPOSIT ENROLLMENT

IMPORTANT: You can use this form to enroll in Direct Deposit or to make a change to an existing direct deposit account. Please read the Privacy Act and Respondent Burden information shown below.

ATTENTION VA BENEFICIARY!
WE'VE MADE ENROLLING IN DIRECT DEPOSIT EASIER THAN EVER!
CALL TOLL FREE - 1-800-827-1000
or TDD 1-800-829-4833 (Telephone Device for the Hearing Impaired)

Direct Deposit is the safest, fastest and most cost efficient method to receive your payment. In addition, you no longer have to worry about your check being late, lost, or stolen. NOTE: The "Debt Collection Improvement Act of 1996" which was signed into law on April 26, 1996 required all Federal payments to be made by Electronic Fund Transfer (EFT or Direct Deposit) beginning January 1, 1999. Waivers will be available where the conversion from paper checks imposes a hardship. Write to the address shown below for more information concerning a waiver. To have your VA compensation, pension, education, or spina bifida payment deposited into your account right away with Direct Deposit just call VA's toll-free number above or complete this form and mail to:

Department of Veterans Affairs
125 S. Main Street Suite B
Muskogee OK 74401-7004

When you call, be sure to have a personal check or bank statement available as well as your VA Claim Number or Social Security Number. The VA representative will ask for information from these documents to start your Direct Deposit. If you prefer to enroll by mail, just complete the information below, and attach a voided personal check from your checking account or call your Financial Institution and verify the information requested below for a savings account.

Privacy Act Notice: VA will not disclose information collected on this form to any source other than what has been authorized under the Privacy Act of 1974 or Title 38, Code of Federal Regulations 1.576 for routine uses as identified in the VA system of records, 58VA21/22/28, Compensation, Pension, Education, Vocational Rehabilitation and Employment Records - VA, published in the Federal Register. Your obligation to respond is voluntary. The information solicited under authority of Title 31 Code of Federal Regulations, Section 210.4 will be used to process the payment data from VA to your account at the designated financial institution. Giving us your Social Security Number (SSN) is mandatory. Applicants are required to provide their SSN under Title 38, U.S.C. 5101 (c) (1). VA will not deny an individual benefits for refusing to provide his or her SSN unless the disclosure of the SSN is required by a Federal Statute of law in effect prior to January 1, 1975, and still in effect. The requested information is considered relevant and necessary to determine maximum benefits provided by law. The responses you submit are considered confidential (38 U.S.C. 5701).

Respondent Burden: We need this information to ensure proper transmission of your funds via electronic transfer to your financial institution (31 CFR 208.3 and 210.4). Title 38, United States Code, allows us to ask for this information. We estimate that you will need an average of 15 minutes to review the instructions, find the information, and complete this form. VA cannot conduct or sponsor a collection of information unless a valid OMB control number is displayed. You are not required to respond to a collection of information if this number is not displayed. Valid OMB control numbers can be located on the OMB Internet Page at www.reginfo.gov/public/do/PRAMain. If desired, you can call 1-800-827-1000 to get information on where to send comments or suggestions about this form.

SECTION I: VETERAN'S IDENTIFICATION INFORMATION

NOTE: You can *either* complete the form online or by hand. Please print the information requested in ink, neatly and legibly to help process the form.

1. VETERAN'S NAME *(First, Middle Initial, Last)*

2. SOCIAL SECURITY NUMBER

3. VA FILE NUMBER

4. DATE OF BIRTH *(MM/DD/YYYY)*
Month – Day – Year

SECTION II: BENEFICIARY'S IDENTIFICATION INFORMATION

5. BENEFICIARY'S NAME *(First, Middle Initial, Last - If other than veteran)*

6. SOCIAL SECURITY NUMBER

7. VA FILE NUMBER

8. TYPE OF BENEFIT

9. ADDRESS OF PERSON RECEIVING PAYMENT *(Check box if new* ☐ *)*

SECTION III: FINANCIAL INSTITUTION INFORMATION

PLEASE ATTACH A VOIDED PERSONAL CHECK AND SKIP TO SECTION III OR CALL YOUR FINANCIAL INSTITUTION FOR THE FOLLOWING INFORMATION:

10. ROUTING TRANSIT NUMBER

11. ACCOUNT NUMBER *(Please check the appropriate box)* ☐ CHECKING ☐ SAVINGS

12. NAME OF FINANCIAL INSTITUTION

13. ADDRESS OF FINANCIAL INSTITUTION

14. TELEPHONE NUMBER OF FINANCIAL INSTITUTION *(Include Area Code)*

SECTION IV: PAYEE CERTIFICATION

I CERTIFY THAT I am entitled to the payment above, and that I have read and understand this form. In signing this form, I authorize my payment to be sent to the financial institution named above, to be deposited to the designated account.

15. SIGNATURE OF PAYEE *(Do NOT print - Sign in ink)*	16. DATE SIGNED	17. TELEPHONE NUMBER *(Include Area Code)*

Family Counseling Service
"HELPING HEARTS AND HOMES."

PAYEE CONTRACT

I, _____, have chosen Family and Payee Counseling Service to pay my all my bills, including, but not limited to, utilities, medical, and other various monthly recurring bills.

I agree to:

_____ Be clean and sober when I come into the facility to conduct business

_____ Treat all staff with courtesy and respect

_____ Demonstrate appropriate personal hygiene maintenance

_____ If prescribed, take my medication on a regular basis

_____ Properly maintain a permanent living address and, in the event of vacating my current living address, I will immediately notify the Payee staff of my new living arrangements.

_____ Come to conduct business only on Monday, Tuesday, Wednesday and Friday between 9:00 A.M. and 3:30 P.M.

_____ Receive my living allowance money ***once-a-week*** between 9:00 A.M. and 3:30 P.M., as agreed, and set-up my SSA funds to be received by Family and Payee Counseling Service. THE SET-UP DAY IS SUBJECT TO CHANGE MONTHLY.

_____ Sign a receipt when I receive my spending money

_____ In the event of a financial emergency, I agree to contact Family and Payee Counseling Service

_____I understand that if I fail to comply with the rules, as stated above, Family Counseling Service of Northern Nevada, Inc, may refuse to continue to serve as my Payee Representative.

Family Counseling Service
"HELPING HEARTS AND HOMES."

Family Counseling Service of Northern Nevada will:

_____Treat me with courtesy and respect;

_____Be available on Monday, Tuesday, Wednesday and Friday between 9:00 AM and 3:30 PM to meet with me;

_____Disperse my living allowance funds, once-a- week, between 9:00 AM and 3:30 PM, as agreed, and set up, according to the day of the week, my SSA funds. Said funds are to be received by Family Counseling Service. THIS DAY IS SUBJECT TO CHANGE MONTHLY;

_____Use funds received on my behalf to meet my current needs for food and housing;

_____Report to SSA any events that may affect my eligibility for payments or payment amount;

_____Report to SSA and accounting of my money – whether it has been spent or saved;

_____Save unspent funds, if any, in a way that clearly shows the funds belong to me; and

_____ In the event of a change in my payee, Family Counseling Service will return to SSA any funds left over in my account.

Beneficiary

Signature and Date

Organization

Signature and Date

NOTE: This contract is not an agreement to collect fees for payee services.

Family Counseling Service
"HELPING HEARTS AND HOMES."

1475 Terminal Way Suite B,
Reno, NV 89502

AUTHORIZATION FOR THE RELEASE AND RECEIPT OF ACCOUNT/ FINANCIAL INFORMATION

CLIENT NAME_____DATE OF BIRTH_____SS#_____

I CONSENT TO RELEASE THE FOLLOWING INFORMATION. Client Initial:____
INCLUDING BUT NOT LIMITED TO

ALL ACCOUNT NUMBERS_____ ACCOUNT BALANCES_____

PAYMENT HISTORY_____

OTHER (specify)_____
TO:

AGENCY OR PROVIDER NAME:_____
ADDRESS:_____
_____

FROM: FAMILY COUNSELING SERVICE_____
AGENCY OR PROVIDER NAME:_____
ADDRESS:_____
_____

FOR THE PURPOSE OF:
_____To collect and coordinate account information and payments
_____For coordination of treatment
_____Other_____

THIS CONSENT IS IN EFFECT FROM: _____ TO _____
AND MAY BE CANCELLED IN WRITING AT ANY TIME UNLESS PROVIDER HAS TAKEN ACTION IN RELIANCE UPON IT. I HAVE READ THIS FORM AND UNDERSTAND IT AND HAVE THE RIGHT TO RECEIVE A COPY. I UNDERSTAND I MAY REFUSE TO SIGN THIS FORM TO RELEASE MY CONFIDENTIAL TREATMENT RECORDS. PROVIDER SHALL NOT CONDITION TREATMENT UPON CLIENT SIGNING THIS AUTHORIZATION. I RELEASE FAMILY COUNSELING SERVICE FROM ANY LIABILITY FOR THE RELEASE OF MY RECORDS.

CLIENT OR LEGAL GUARDIAN_____ DATE_____
WITNESS_____ DATE_____

This notice accompanies a disclosure of information concerning a client, made to you with the consent of such client. This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR Part 2 and H.I.P.A.A.). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2 and H.I.P.A.A. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

REPRESENTATIVE PAYEE - MONTHLY BUDGET

Client Name:		Date:	
Income Source 1	x SSA ☐ SS ☐ RR ☐ VA ☐ **SSA delivered** **of month**	Amount:	
Income Source 2	☐ SSA ☐ SSI ☐ RR ☐ VA ☐ Other:	Amount:	
		TOTAL MONTHLY INCOME	$ 0.00

EXPENSES		FREQUENCY	TOTAL EXPENSE
RENT or MORTGAGE:			
CO & ACCT NO:		Monthly	
Address			
INSURANCE: Home, Car, Life, Renters, Health, Other			
CO & ACCT NO:	/	Monthly	
Address	Street: CITY,ST, ZIP:		
Nv Energy bill monthly			
CO & ACCT NO:	/	Monthly	
Address	Street: CITY,ST, ZIP:		
PHONE: Cell or Home			
CO & ACCT NO:	/	Monthly	
Address	Street: CITY,ST, ZIP:		
CABLE: Charter Communication			
CO & ACCT NO:		Monthly	
Address	Street: CITY,ST, ZIP:		
CO & ACCT NO:	/	Monthly	
Address	Street: CITY,ST, ZIP:		
CO & ACCT NO:	/	Monthly	
Address	Street: CITY,ST, ZIP:		
TRANSPORTATION: Bus Pass disabled			
CO & ACCT NO:		Monthly	
Address	Street: CITY,ST, ZIP:		
Medications			
CO & ACCT NO:	/	Monthly	
Address	Street: CITY,ST, ZIP:		
OTHER:			
CO & ACCT NO:		Monthly	
Address	Street: CITY,ST, ZIP:		
REP PAYEE MONTHLY FEE:		Monthly	*(doesn't calculate)*
CO & ACCT NO:	/		
SPENDING MONEY:		Monthly	*(doesn't calculate)*
Notes:		Monthly total	
	TOTAL MONTHLY EXPENSES		$ 0.00

Monthly Savings	**Income:**	**Expenses:**	**SAVINGS** $ 0.00

I agree to this monthly budget as developed in conjunction with my Social Worker.
I understand this budget is for a period of one year. No changes will be made unless it is a medical emergency that requires an immediate payment, death in the family or medical attention for my pet.

Client:	Date:	Social Worker:	Date: