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
www.fcsnv.org All information held strictly confidential

BLUE INK ONLY

Last Name: _____ First Name: _____ Todays Date: _____

Address: _____ Phone _____ 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: _____

Housing Information

Landlord: _____ Amount: _____ Phone: _____

Address: _____

City: _____ State: __ Zip: _____

	Vendor	Vendor	Vendor
Power:			
Gas:			
Water:			
Telephone:			

Allocations of remaining funds

	Vendor	Frequency	Amount
Food:			
Pers. Use:			

Client Notes:

SOCIAL SECURITY ADMINISTRATION TOE 250

Form Approved
OMB No. 0960-0014

REQUEST TO BE SELECTED AS PAYEE

PRINT IN INK:

FOR SSA USE ONLY							
Name or Bene. Sym.	Program	Date of Birth	Type	Gdn.	Cus.	Inst.	Nam.

FOR SSA USE ONLY

DISTRICT OFFICE CODE

STATE AND COUNTY CODE

X The name of the NUMBER HOLDER

SOCIAL SECURITY NUMBER
X

The name of the PERSON(S) (if different from above) for whom you are filing (the "claimant(s)")

SOCIAL SECURITY NUMBER(S)

Answer item 1 ONLY if you are the claimant and want your benefits paid directly to you.

1. I request that I be paid directly.
CHECK HERE ☐ and answer only items 3, 5, 6, and 8 before signing the form on page 4.

I REQUEST THAT THE SOCIAL SECURITY, SUPPLEMENTAL SECURITY INCOME, OR SPECIAL VETERANS BENEFITS FOR THE CLAIMANT(S) NAMED ABOVE BE PAID TO ME AS REPRESENTATIVE PAYEE.

2. Explain why you think the claimant is not able to handle his/her own benefits. (In your answer, describe how he/she manages any money he/she receives now.)

Client has been requested by Soc. Sec. to obtain a payee.

☐ Claimant is a minor child

3. Explain why you would be the best representative payee. (Use Remarks if you need more space.)

We have been providing Services for over 10 years.

4. If you are appointed payee, how will you know about the claimant's needs?

☐ Live with me or in the institution I represent
☐ Daily visits
☐ Visits at least once a week.
☐ By other means. Explain:

5. Does the claimant have a court-appointed legal guardian/conservator? ☐ YES ☒ NO

IF YES, enter the legal guardian/conservator's:

NAME _____

ADDRESS _____

PHONE NUMBER _____

TITLE _____

DATE OF APPOINTMENT _____

Explain the circumstances of the appointment. (Use remarks if you need more space.)

6. (a) Where does the claimant live?

- ☐ Alone
- ☐ In my home (Go to (b).)
- ☐ With a relative (Go to (b).)
- ☐ With someone else (Go to (b).)
- ☐ In a board and care facility (Go to (b).)
- ☐ In a public institution (Go to (c).)
- ☐ In a private institution (Go to (c).)
- ☐ In a nursing home (Go to (c).)
- ☐ In the institution I represent (Go to (c).)

(b) Enter the names and relationships of any other people who live with the claimant.

NAME	RELATIONSHIP

(c) Enter the claimant's residence and mailing addresses (if different from yours).
Residence: Mailing: Telephone Number:

(d) Do you expect the claimant's living arrangements to change in the next year?
☐ YES ☒ NO If YES, explain what changes are expected and when they will occur. (Use Remarks if you need more space.)

7. If you are applying on behalf of minor child(ren) and you are not the parent,
Does the child(ren) have a living natural or adoptive parent? ☐ YES ☐ NO
If YES, enter: (a) Name of parent _____
(b) Address of parent _____
(c) Telephone number _____
(d) Does the parent show interest in the child? ☐ YES ☐ NO
Please explain. _____

8. List the names and relationship of any (other) relatives or close friends who have provided support and/or show active interest with the claimant. Describe the type and amount of support and/or how interest is displayed.

NAME	ADDRESS/PHONE NO.	RELATIONSHIP	DESCRIBE

9. Check the block that describes your relationship to the claimant.

(a) ☐ Official of bank, agency or institution with responsibility for the person. Enter below which you represent:
- ☐ Bank
- ☐ Social Agency
- ☐ Public Official
- ☐ Institution:
  - ☐ Federal
  - ☐ State/Local
  - ☒ Private non-profit
  - ☐ Private proprietary institution. Is the institution licensed under State law? ☐ YES ☐ NO

IF (a) ABOVE CHECKED, COMPLETE ONLY QUESTIONS 10 AND 11 AND SIGN THE FORM ON PAGE 4.

(b) ☐ Parent
(c) ☐ Spouse
(d) ☐ Other Relative - Specify
(e) ☐ Legal Representative
(f) ☐ Board and Care Home Operator
(g) ☐ Other Individual - Specify

IF (b), (c), (d), or (e) ABOVE CHECKED, GO ON TO QUESTION 12

10. Does the claimant owe you/your organization any money now or will he/she owe you money in the future? ☐ YES ☐ NO

If YES, enter the amount he/she owes you/your organization, the date(s) was/will be incurred and describe why the debt was/will be incurred.

INFORMATION ABOUT INSTITUTIONS, AGENCIES AND BANKS APPLYING TO BE REPRESENTATIVE PAYEE

11. (a) Enter the name of the institution Family Counseling Service of N. NV.

(b) Enter the EIN of the institution 88-0090713

INFORMATION ABOUT INDIVIDUALS APPLYING TO BE REPRESENTATIVE PAYEE

12. Enter: YOUR NAME _____

DATE OF BIRTH _____

SOCIAL SECURITY NUMBER _____

ANY OTHER NAME YOU HAVE USED _____

OTHER SSN'S YOU HAVE USED _____

13. How long have you known the claimant? _____

14. If the claimant lives with you, who takes care of the claimant when work or other activity takes you away from home?

What is his/her relationship to the claimant?

15. (a) Main source of your income

- ☐ Employed (answer (b) below)
- ☐ Self-employed (Type of Business _____)
- ☐ Social Security benefits (Claim Number _____)
- ☐ Pension (describe _____)
- ☐ Supplemental Security Income payments (Claim Number _____)
- ☐ AFDC (County & State _____)
- ☐ Other Welfare (describe _____)
- ☐ Other (describe _____)

(b) Enter your employer's name and address:

How long have you been employed by this employer? _____

(If less than 1 year, enter name and address of previous employer in Remarks.)

16. (a) Have you ever been convicted of a felony? ☐ YES ☐ NO

If YES: What was the crime? _____

On what date were you convicted? _____

What was your sentence? _____

If imprisoned, when were you released? _____

If probation was ordered, when did/will your probation end? _____

(b) Have you ever been convicted of any offense under federal or state law which resulted in imprisonment for more than one year? ☐ YES ☐ NO

If YES: What was the crime? _____

On what date were you convicted? _____

What was your sentence? _____

If imprisoned, when were you released? _____

If probation was ordered, when did/will your probation end? _____

17. Do you have any unsatisfied FELONY warrants (or in jurisdictions that do not define crimes as felonies, a crime punishable by death or imprisonment exceeding 1 year) for your arrest? ☐ YES ☐ NO

If YES: Date of Warrant _____

State where warrant was issued: _____

18. How long have you lived at your current address? (Give Date MM/YY)

REMARKS: *(This space may be used for explaining any answers to the questions. If you need more space, attach a separate sheet.)*

PLEASE READ THE FOLLOWING INFORMATION CAREFULLY BEFORE SIGNING THIS FORM

I/my organization:

- Must use all payments made to me/my organization as the representative payee for the claimant's current needs or (if not currently needed) save them for his/her future needs.
- May be held liable for repayment if I/my organization misuse the payments or if I/my organization am/is at fault for any overpayment of benefits.
- May be punished under Federal law by fine, imprisonment or both if I/my organization am/is found guilty of misuse of Social Security or SSI benefits.

I/my organization will:

- Use the payments for the claimant's current needs and save any currently unneeded benefits for future use.
- File an accounting report on how the payments were used, and make all supporting records available for review if requested by the Social Security Administration.
- Reimburse the amount of any loss suffered by any claimant due to misuse of Social Security or SSI funds by me/my organization.
- Notify the Social Security Administration when the claimant dies, leaves my/my organization's custody or otherwise changes his/her living arrangements or he/she is no longer my/my organization's responsibility.
- Comply with the conditions for reporting certain events (listed on the attached sheets(s) which I/my organization will keep for my/my organization's records) and for returning checks the claimant is not due.
- File an annual report of earnings if required.
- Notify the Social Security Administration as soon as I/my organization can no longer act as representative payee or the claimant no longer needs a payee.

I declare under penalty of perjury that I have examined all the information on this form, and on any accompanying statements or forms, and it is true and correct to the best of my knowledge.

SIGNATURE OF APPLICANT	DATE *(Month, day, year)*
Signature *(First name, middle initial, last name) (Write in ink)*	Telephone number(s) at which you may be contacted during the day (775) 822-6557

Print Your Name & Title *(if a representative or employee of an institution/organization)*

Jennifer L. Williams

Mailing Address *(Number and street, Apt. No., P.O. Box, or Rural Route)*

1475 Terminal Way ste B

City and State	Zip Code	Name of County
RENO NV	89502	WASHOE

Residence Address *(Number and street, Apt. No., P.O. Box, or Rural Route)*

City and State	Zip Code	Name of County

Witnesses are only required if this application has been signed by mark (X) above. If signed by mark (X), two witnesses to the signing who know the applicant making the request must sign below, giving their full addresses.

1. SIGNATURE OF WITNESS	2. SIGNATURE OF WITNESS
ADDRESS *(Number and street, City, State and ZIP Code)*	ADDRESS *(Number and street, City, State and ZIP Code)*

SPECIAL BENEFITS FOR WORLD WAR II VETERANS
Information for Representative Payees Who Receive Special Benefits for WW II Veterans

YOU MUST NOTIFY THE SOCIAL SECURITY ADMINISTRATION PROMPTLY IF ANY OF THE FOLLOWING EVENTS OCCUR AND PROMPTLY RETURN ANY PAYMENT TO WHICH THE CLAIMANT IS NOT ENTITLED:

- the claimant DIES (special veterans entitlement ends the month after the claimant dies);
- the claimant returns to the United States for a calendar month or longer;
- the claimant moves or changes the place where he/she actually lives;
- the claimant receives a pension, annuity or other recurring payment (includes workers' compensation, veterans benefits or disability benefits), or the amount of the annuity changes;
- the claimant is or has been deported or removed from U.S.;
- the claimant has an UNSATISFIED FELONY WARRANT (or in jurisdictions that do not define crimes as felonies, a crime punishable by death or imprisonment exceeding 1 year) issued for his/her arrest;
- the claimant is violating a condition of probation or parole under State or Federal law.

In addition to these events about the claimant, you must also notify us if:

- YOU change your address;
- YOU are convicted of a felony or any offense under State or Federal law which results in imprisonment for more than 1 year;
- YOU have an UNSATISFIED FELONY WARRANT (or in jurisdictions that do not define crimes as felonies, a crime punishable by death or imprisonment exceeding 1 year) issued for your arrest.

BENEFITS MAY STOP IF ANY OF THE ABOVE EVENTS OCCUR. You can make your reports by telephone, mail or in person. You can contact any U.S. Embassy, Consulate, Veterans Affairs Regional Office in the Philippines or any U.S. Social Security Office.

REMEMBER:

- payments must be used for the claimant's current needs or saved if not currently needed;
- you may be held liable for repayment of any payments not used for the claimant's needs or of any overpayment that occurred due to your fault;
- you must account for benefits when so asked by the Social Security Administration. You will keep records of how benefits were spent so you can provide us with a correct accounting;
- to let us know, as soon as you know you are unable to continue as representative payee or the claimant no longer needs a payee.

Advance Notification of Representative Payment

Name of Wage Earner, Self-Employed Person or SSI Claimant	Social Security Number
X	X

Name of Beneficiary (if other than above)	Relationship to Wage Earner, Self-Employed Person or SSI Claimant

I understand and agree with the following.

Need for Representative Payee

The Social Security Administration (SSA) has decided that I need someone to manage my benefits. Because of this, SSA will send my benefits to a representative payee. It is the duty of the representative payee to use my benefits for my best interests.

Choice of Representative Payee

SSA has selected Family Counseling Service to be my representative payee.

My Right to Appeal

I understand that I have the right to appeal SSA's decision. I can appeal the choice of who will be the representative payee. In most cases, I can also appeal the decision that I need a payee. If I appeal, I will have the right to review the evidence in file and submit new evidence. I understand that I can have a friend, lawyer or someone else to help me.

I understand that I must file an appeal within 60 days. If I file after the 60 day period, I must have a good reason for not having filed this appeal on time. I have to ask for the appeal in writing. I will contact an SSA office if I wish to appeal.

X _____	X _____
Signature	Date

Witnesses are required only if this statement has been signed by mark (X) above. If signed by mark (X), two witnesses to the signing who know the person making the statement must sign below, giving their full addresses.

1. Signature of Witness	2. Signature of Witness
Address (Number and Street, City, State and ZIP Code)	Address (Number and Street, City, State and ZIP Code)

Form **SSA-4164** (9-1994) (EF 8-2000)
Destroy prior editions

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.

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.

US Bank Focus Card Visa application

NAME_____ todays date_____

Address_____city_____

State_____ Zip Code_____

Date of Birth_____ Social Security #_____

Phone # _____

Place of Birth _____

Mother's maiden name _____

Signature_____