Social Security Administration

Form Approved
OMB No. 0960-0024

PHYSICIAN'S/MEDICAL OFFICER'S STATEMENT OF PATIENT'S CAPABILITY TO MANAGE BENEFITS

In replying, use this address: SOCIAL SECURITY ADMINISTRATION	TELEPHONE NUMBER (Including Area Code) DATE

SSA CONTACT

IDENTIFYING INFORMATION (SSA Only)
If different from patient

NAME OF WAGE EARNER OR SELF-EMPLOYED PERSON	SOCIAL SECURITY NUMBER

PATIENT'S NAME

PATIENT'S SOCIAL SECURITY NUMBER	PATIENT'S DATE OF BIRTH

PATIENT'S ADDRESS (Number and Street, City, State, and ZIP Code)

YOUR HELP IS NEEDED

The patient shown above has filed for or is receiving Social Security or Supplemental Security Income payments. We need you to complete the back of this form and return it to us in the enclosed envelope to help us decide if we should pay this person directly or if he or she needs a representative payee to handle the funds. Please Note: This determination affects how benefits are paid and has no bearing on disability determinations; SSA will NOT pay for this information. Thank you for your help.

WHO IS A REPRESENTATIVE PAYEE

A representative payee is someone who manages the patient's money to make sure the patient's needs are met. The payee has a strong and continuing interest in the patient's well-being and is usually a family member or close friend.

WHO NEEDS A REPRESENTATIVE PAYEE

Some individuals age 18 and older who have mental or physical impairments are not capable of handling their funds or directing others how to handle them to meet their basic needs, so we select a representative payee to receive their payments. Examples of impairments which may cause incapability are senility, severe brain damage or chronic schizophrenia. However, even though a person may need some assistance with such things as bill paying, etc., does not necessarily mean he/she cannot make decisions concerning basic needs and is incapable of managing his/her own money.

PLEASE COMPLETE THE INFORMATION ON THE REVERSE OF THIS FORM

PATIENT'S NAME

PATIENT'S SOCIAL SECURITY NUMBER | PATIENT'S DATE OF BIRTH

PATIENT'S ADDRESS (Number and Street, City, State, and ZIP Code)

1. Date you last examined the patient

2. Do you believe the patient is capable of managing or directing the management of benefits in his or her own best interest? By capable we mean the patient:

- Is able to understand and act on the ordinary affairs of life, such as providing for own adequate food, housing, clothing, etc., and
- Is able, in spite of physical impairments, to manage funds or direct others how to manage them.

☐ Yes
If "Yes", please omit question 3, but be sure to sign and date the form.

☐ No
If "No", please provide a brief summary of the findings that led to this conclusion. Also, complete question 3.

☐ Unsure
If "Unsure", please explain.

3. Do you expect the patient to be able to manage funds in the future (for example, the patient is temporarily unconscious)?

☐ Yes ☐ No

If yes, please explain.

NAME OF PHYSICIAN/MEDICAL OFFICER (Please print.) | TITLE

ADDRESS (Number and street, City, State, and ZIP Code) | TELEPHONE NUMBER (*Include Area Code*)

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. I understand that anyone who knowingly gives a false statement about a material fact in this information, or causes someone else to do so, commits a crime and may be subject to a fine or imprisonment.

SIGNATURE OF PHYSICIAN/MEDICAL OFFICER | DATE

FAMILY COUNSELING PAYEE DEPARTMENT
1475 TERMINAL WAY, SUITE D, RENO, NV 89502
OFFICE: 775-322-6557 / FAX: 775-322-6930

$54
PAYEE FEE

** Client Fact Sheet**

Race: African American__ White__ Hispanic/Latino__
Native American/PI__ Asian__ Other__

Date: _____/_____/_____
Name: _____
Date of Birth: _____/_____/_____
Birth City & State: _____
SS#: _____-_____-_____ Gender: (M,F,Non-Binary, Transgender, Other)_____
Marital Status: _____
Name of ALF/Nursing Home/another facility, if applicable:
_____
Address: _____
City/State/Zip: _____
Phone Number: (_____) _____-_____
How much is your rent? _____
Mother's Maiden Name: _____
Next of Kin Name: _____
Next of Kin Phone Number: (_____) _____-_____
Former Payee Name: _____
Former Payee Address: _____
Former Payee Phone Number: (_____) _____-_____

fill out entire page

** Income (Please check all that apply) **

Income Source:

- ☐ SSA $_____ Receive on _____ day of each month
- ☐ SSD $_____ Receive on _____ day of each month
- ☐ SSI $_____ Receive on _____ day of each month
- ☐ VA $_____ Receive on _____ day of each month
  Branch Of Service _____
- ☐ Other: _____ Receive on _____ day of each month

Do you receive food stamps/Medicaid? ☐ NO ☐ YES- Amount $_____ _____
Do you have a bank account? ☐ NO ☐ YES- Name of Bank: _____
Do you have a Life Insurance Policy? ☐ NO ☐ YES
Do you have a Trust account? ☐ NO ☐ YES

** Case Manager Information **

Case Manager Name: _____
Case Manager Phone Number: (_____) _____-_____, Ext _____
Agency Name: _____

Family Counseling Services of Northern Nevada

Voluntary Self-Disclosure of Gender & Race/Ethnicity

COMPLETING THIS FORM IS VOLUNTARY AND IS NOT A REQUIREMENT FOR SERVICES.

Family Counseling Services of Northern Nevada believes that all persons are entitled to equal employment opportunities, and we do not discriminate against our employees, applicants, or job seekers because of their race, color, gender, religion, national origin, disability, veteran status, age, marital status, sexual orientation, genetic information or any other protected group status as defined by law.

We are subject to certain governmental recordkeeping and reporting requirements, including for theadministration of civil rights laws and regulations. In order to comply with these laws, we invite you to voluntarily self-identify your race, ethnicity, and gender. Submission of this information is voluntary, and refusal to provide it will not influence our screening or service decisions and will not subject you to discharge, disciplinary or other adverse treatment. The information obtained will be kept confidential and separate from your application and/orpersonnel records and will only be used in accordance with the provisions of applicable laws, executive orders, and regulations.

Please complete the self-identification form below, which includes the option to choose not to self-identify, and return it to us as soon as possible.

YOUR NAME (PRINT):

LAST_____ **FIRST** _____ **DATE**_____

YOUR GENDER (CHOOSE ONE):

- ☐ Female
- ☐ Male
- ☐ I choose not to self-identify
  (We need to add nonbinary and transgender to the list)

YOUR RACE/ETHNICITY (CHOOSE ONE):

- ☐ Hispanic or Latino
- ☐ White (Not Hispanic or Latino)
- ☐ Black or African American (Not Hispanic or Latino)
- ☐ Asian (Not Hispanic or Latino)
- ☐ Native Hawaiian or Other Pacific Islander (Not Hispanic or Latino)
- ☐ American Indian or Alaska Native (Not Hispanic or Latino)
- ☐ Two or More Races (Not Hispanic or Latino)
- ☐ I choose not to self-identify

RACE/ETHNIC DEFINITIONS:

Hispanic or Latino: A person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin regardless of race
White (Not Hispanic or Latino): A person having origins in any of the original peoples of Europe, the Middle East, or North Africa
Black or African American (Not Hispanic or Latino): A person having origins in any of the black racial groups of Africa
Asian (Not Hispanic or Latino): A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian Subcontinent including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam
Native Hawaiian or Other Pacific Islander (Not Hispanic or Latino): A person having origins in any of the peoples of Hawaii, Guam, Samoa, or other Pacific Islands
American Indian or Alaska Native (Not Hispanic or Latino): A person having origins in any of the original peoples of North and South America (including Central America) and who maintain tribal affiliation or community attachment
Two or More Races (Not Hispanic or Latino): Persons who identify with two or more race/ethnic categories named above

Family Counseling Service
"HELPING HEARTS AND HOMES."

1475 TERMINAL WAY STE. B
RENO, NV 89502
PHONE: (775) 329-0623
FAX: (775) 337-2971

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____ initial ACCOUNT BALANCES____ initial

PAYMENT HISTORY____initial

OTHER (specify)_____ if applicable

TO:

AGENCY OR PROVIDER NAME:_____
ADDRESS:_____
_____

FROM: FAMILY COUNSELING SERVICE____ initial
AGENCY OR PROVIDER NAME:_____
ADDRESS:_____
_____

FOR THE PURPOSE OF:

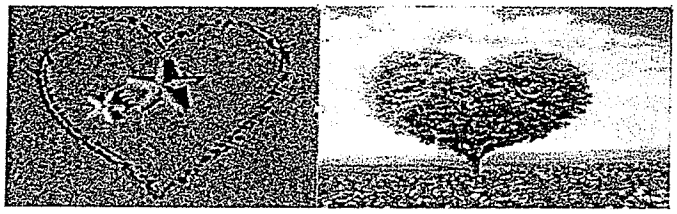
tial ____To collect and coordinate account information and payments
itial ____For coordination of treatment
itial ____Other_____

DATE OF SIGN. ONE YEAR initial

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_____ sign DATE_____ 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 AGREEMENT

CLIENT UNDERSTANDS THAT COMPANY WILL PROVIDE THE FOLLOWING:

My benefits check will be either mailed or direct deposited to the Company who will set up a bank account under the name of River City Bank.

With the assistance of the Company, I will develop a budget that lists everything that I owe (Budget will accompany this Agreement).

I will not open charge/bank accounts or obtain loans unless it is first put into my budget. Company will pay monthly bills from the income that is listed on the Budget Sheet. I must turn receipts for money spent.

COMPANY GUARANTEES THE FOLLOWING:

Company does not provide transportation but will assist in arranging transportation Service Company shall make all scheduled payments either by check or bank transfer; any late fee associated with payment will be assumed by Company.

All rent payments will be made for the 3rd of the month for the upcoming period of occupancy. Weekly Personal needs checks will be used for food and other weekly expenses; Clients will receive only one payment per week.

All requests for personal needs payments must be made at least 7 days prior to payment. Clients must inform Company in writing at least 30 days in advance if wanting to move. Company will be closed on all government holidays as well as if Washoe County schools are closed due to bad weather.

CLIENT MUST INFORM COMPANY IF:

- I receive assistance from any other agency or welfare department. I go to jail or prison.
- I am admitted to the hospital or nursing home.
- I begin working, quit working, receive money or save money.
- I get married or divorced.

I take a trip outside of Nevada. If you do not report the above changes to us, you may receive an overpayment and be required to pay money back to Social Security Administration and/or lose your benefits.

CLIENTS CASE MAY BE CLOSED IF:

• I am verbally or physically abusive or threaten Company staff in any manner

• I bring any drugs or weapons to this office

• I come to the office under the influence of illegal drugs or alcohol.

• I am arrested for any reason.

• I move out of the area

• I panhandle on the property

• I refuse to follow my budget or are non-compliant with any aspect of the program. CLIENT HAS A RIGHT TO:

• Professional and courteous service.

• Participate in goal setting and have the program fully explained to me.

• Service without discrimination based on sex, race, ethnicity, sexual orientation, disability. Creed, religion, or national origin.

• Receive total confidentiality, No information will be shared about me with anyone outside of

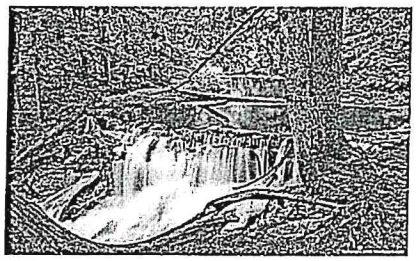
- • Company without written permission or due process of law.

• Receive truthfulness, knowing that my benefits are being monitored under the Social Security Administration.

• File a grievance if I believe my Rights have been violated.

• Refuse services at any time by giving Company at least a 30 day notice.

ENTIRE AGREEMENT: This Contract contains the entire agreement of Client, and Company, Family Counseling, and replaces any other prior agreement in its entirety. It may not be changed orally, but only by an agreement in writing signed by both parties.



FAMILY COUNSELING SERVICE AGREEMENT

I [redacted] hereby appoint Family Counseling Service to be my designated Representative Payee for my Social Security, SSI, SSD, or other income. Client agrees to allow Family Counseling Service to receive my benefits on my behalf, and be responsible to pay financial obligations to the extent that there are funds available funds in your account to do so. Client agrees to pay a monthly fee, set by the Social Security Administration, for the performance of these duties.

Family Counseling Service will pay Rent, Utilities, Food or (Room & Board), and other scheduled monthly payments directly to the service provider. Family Counseling Service will provide a weekly personal needs payment to the client to the extent that Family Counseling Service has the client funds to do so. Family Counseling Service shall provide all designated Representative Payee services as prescribed by the law and social security regulation.

X Paisley McKay

REPRESENTATIVE PAYEE

X

CLIENT SIGNATURE

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

The name of the NUMBER HOLDER
X

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.) They decided they need help in managing their money.

☐ Claimant is a minor child

3. Explain why you would be the best representative payee. (Use Remarks if you need more space.)
Please look at the remarks column.

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: If they're unable to come in, they may call us.

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?

- [X] 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 [X] 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
- [X] Institution:
  - [ ] Federal
  - [ ] State/Local
  - [X] 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. The Claimant will owe us $54 a month for a payee fee.

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

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

(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 _____)
- ☐ Temporary Assistance For Needy Families (TANF _____)
- ☐ Other State or Public Assistance (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. Do you give Social Security permision to conduct a criminal background check on you? ☐ YES ☐ NO

17. (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? _____

18.	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_____
19.	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.)* We have recently implemented software specific to Representative Payee Programs that allow us to serve our clients by eliminating human error. We have been providing payee services for decades, and we take pride in the relationships we build with clients. Family Counseling Service is the best choice for payee representatives.

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)* Paisley McKay	Telephone number(s) at which you may be contacted during the day 775-322-6557

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

Mailing Address *(Number and street, Apt. No., P.O. Box, or Rural Route)*
1475 Terminal Way Suite D

City and State	Zip Code	Name of County
Reno, Nevada	89502	Washoe

Residence Address *(Number and street, Apt. No., P.O. Box, or Rural Route)*
1475 Terminal Way Suite D

City and State	Zip Code	Name of County
Reno, Nevada	89502	Washoe

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)*

Advance Notification of Representative Payment

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

X _____ 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