Guardian Angel Life Services, Inc.

a private, non-profit, service and supports agency

P.O. Box 260 Kenesaw, NE 68956
gals@guardianangel.biz or ask for your case managers specific email
402-752-3670 402-752-3680 (fax) 402-902-2441 (text)

GALS, Inc.'s priority is to help our members achieve independence by offering protective services and supports, assisting our members to have a more rewarding future, and work toward greater self-sufficiency. We offer assistance to ensure our members have adequate food, shelter, medical care, and other items for personal comfort. In order for us to provide the best service possible, it is pertinent that you provide the following information to us: **if you start/end a job, if you move, if someone moves in/out of your home, if you marry/divorce/have a child, if you are incarcerated**, etc.

Our office hours are Monday, Tuesday, Thursday, Friday 9 am to 4 pm and Wednesday 9 am to 12 noon.

A monthly fee is charged for being representative payee, this amount is designated by the Social Security Administration.

GALS, Inc is excited to have this opportunity to work with you, and are here to help you. Please don't hesitate to call with any questions, especially in the new transition stage. We ask that you keep this form handy as it provides some useful tips.

Budgets:

Your personal budget will be developed based upon the information you provide. It is very important the information be as complete and accurate as possible. Your budget may need adjusting as income/expenses change. Once a budget has been developed, it will be sent to you to be **signed and returned** to *GALS, Inc.*

Weekly checks:

Those receiving a weekly check for groceries or personal spending can be expected to receive them on **Fridays**. Checks are mailed every Tuesday. Please **do not call until Friday,** if you haven't received one.

Additional Funds Requests:

Need to be made by **Fridays at 12 p.m.**, in order to receive them the following week. Requests for additional funds will only be honored if funds are available, the budget allows **AND all receipts from previous requests have been received**. Please try to limit requests to no more than twice monthly.

****Receipts:***

As a Social Security requirement, it is required that receipts for purchases be provided to us. Therefore, no request for funds will be honored until the receipts/verification of receipt of funds is received in the GALS office. **THIS WILL INCLUDE PHONE CARDS/GIFT CARDS/PREPAID VISA/ETC.** Acceptable verification:

1) Return of signed postage paid postcard.
2) Receipts – copies of receipts can be emailed or text to GALS, Inc. PLEASE INCLUDE YOUR NAME ON ALL RECEIPTS TO VERIFY WHO IT IS COMING FROM.

Banking:

GALS, Inc. allows clients to maintain an open Savings account. It is recommended that checking accounts must be closed.

Address Changes:

We prefer that you contact all services to have bills mailed directly to GALS (Phone, utilities, etc.). Please note that GALS, Inc. will not be responsible for late fees, should the bill go directly to the you & then sent to GALS.

PLEASE INCLUDE A COPY OF YOUR LEASE, THIS IS REQUIRED PRIOR TO RENT BEING PAID.

SEEN BY APPOINTMENT ONLY

Once Guardian Angel Life Services, Inc. has been assigned as your Representative payee, we will need the following information to help meet your financial needs. Please fill out the enclosed information page and return it to us as soon as possible.

All information provided will be kept confidential.

Personal Information

NAME	
ADDRESS	
CITY, STATE, ZIP	
HOME PHONE # **Please make sure your phone is not restricted so we are able to contact you**	
ALTERNATE PHONE #	
SOCIAL SECURITY #	
DATE OF BIRTH	
PLACE OF BIRTH	
MOTHERS MAIDEN NAME	
STATUS (Circle One)	Single Married (Spouse name) Divorced Separated
CHILDREN	How many? Living at home? Yes ____ No ____
NAMES OF ALL PERSONS IN HOUSEHOLD THEIR AGE & SOCIAL SECURITY #	
IS ANYONE ELSE IN HOME DISABLED	Yes____ No _____ Receiving any assistance? Yes____ No_____ Name_____ Type? (circle) ADC, SSI, SSA, VA amt:_____
DOES ANYONE ELSE ASSIST WITH LIVING EXPENSES?	Yes____ No _____ If yes, who and what type of assistance is provided?
GUARDIAN NAME	
ADDRESS	
PHONE	
FAMILY CONTACT	
ADDRESS	
PHONE	
ARE YOU or ANYONE IN HOUSEHOLD EMPLOYED?	Yes___ No___ IF SO, WHO & WHERE? Number of hours per week: Rate of Pay:
MEDICAID #	
MEDICARE #	
DISABILITY / DIAGNOSIS	
TYPE OF PAYMENT	**(SSI, AABD, etc)**
MONTHLY PAYMENT AMOUNT	

MY MONTHLY EXPENSES

BANKING ACCOUNT:	*Checking ___Yes __ No* *Bank Name:*	*Savings ___ Yes ___ No* *Bank Name:*	*CD's, Trusts, Burial* *___Yes ___No*
PAYMENTS DUE	*HOW MUCH*	*NAME AND ADDRESS*	*ACCOUNT #* *IF APPLICABLE*
RENT____ OWN____ **Is landlord relative?** **Yes___ No___**	*$* **LEASE NEEDED PRIOR**	**TO RENT BEING PAID**	**COPY OF LEASE NEEDS TO BE PROVIDED**
GAS	*$*		
ELECTRIC	*$*		
WATER/SEWER/ GARBAGE	*$*		
PHONE	*$*		
CABLE	*$*		
GROCERIES	*$ per week*	*Store preference:*	
PERSONAL SPENDING	*$ per week*		
CHILD SUPPORT PAYMENTS	*$*		*CASE#:*
VEHICLES	*$*	*Type: Year:* *Value:*	
LOANS	*$*		
INSURANCE ***Auto __Yes ___No** ***Health __Yes __ No**			
CREDIT CARDS	*$*		
LIFE INSURANCE PREMIUM	*$*	*Cash Value:*	

IS THERE ANYTHING ELSE WE SHOULD KNOW?

_____

_____

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PLEASE RETURN THIS FORM AS SOON AS POSSIBLE TO:
GALS, Inc
PO Box 260
Kenesaw, NE 68956
FAX: 402-752-3680