

**A1 PAYEE SERVICES**  
PO Box 3562  
Durham, NC. 27702-3562  
Phone: (919) 323-8113 Fax: (919) 323-8112  
mkelly009@nc.rr.com

### Representative Payee Application

I hereby authorize A1 Payee Services to manage my benefits and to serve as my organizational representative payee. I understand that the Social Security Administration (SSA) will send my benefits directly to my organizational representative payee. It is the responsibility of my representative payee to manage my benefits in my best interest with my prior knowledge and input, unless I am a minor child, parent, or guardian of the client.

I hereby acknowledge that this consent is truly voluntary and it has been explained to me that A1 Payee Service is working as fee for service business and will collect a fee (set by the Social Security Administration) each month that I receive a benefit check.

Fax Applications to: A1 Payee Services at (919) 323-8112, or, email forms as attachments to mkelly009@nc.rr.com

**Client Information: Please fill out clearly, boldly, and completely.**

Name: \_\_\_\_\_ Social Security #: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Daytime Phone #: \_\_\_\_\_ Evening Phone #: \_\_\_\_\_

Mailing address SSA has on file for you if different from above:

\_\_\_\_\_

Date of Birth: \_\_\_\_\_ State of Birth: \_\_\_\_\_ City of Birth: \_\_\_\_\_

Mother Maiden Name: \_\_\_\_\_ Father's Name: \_\_\_\_\_

Marital Status: \_\_\_ Married \_\_\_ Single \_\_\_ Divorced

Employment: \_\_\_ Employed \_\_\_ Unemployed \_\_\_ Retired

Current Payee name & address:

\_\_\_\_\_

Current Payee Phone #: \_\_\_\_\_

Client/Parent/Guardian/Representative Signature

Date

\_\_\_\_\_

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**CONSENT TO RELEASE OR EXCHANGE INFORMATION**

Client Name: \_\_\_\_\_

Last 4 numbers of Social Security Number: \_\_\_\_\_

DOB: \_\_\_\_\_

I, \_\_\_\_\_ request and authorize A1 Payee Services to use or disclose information to and from all my creditors, debtors, bankers, other financial institutions, and any other organizations/institutions in all matters concerning my Financial, Social, Legal, Developmental, Educational, Vocational, Psychological, Psychiatric, Mental Health, Medical Evaluations, and other data pertaining to housing, entitlement and governmental benefits. This release includes authorization for A1 Payee Services to change billing addresses on my account(s) with the aforementioned company/companies to have my billing statements mailed to A1 Payee Services if needed. I understand that I have the right to revoke this authorization at any time. If I revoke authorization, I must do so in writing and present it to the person/facility/agency that was authorized to release the information, and A1 Payee Services. I understand that revocation will not apply to information that has already been released in response to this authorization. I understand that once the above information is disclosed, the recipient may re-disclose it, and the information may not be protected by federal or state privacy laws or regulations. I understand that authorizing the release or disclosure of the information identified above is voluntary and that this authorization to release my information is considered active while A1 Payee Services remains my Representative Payee. I understand that I do not have to sign this form to receive Representative Payee services from A1 Payee Services.

Signature of Client:

Date:

\_\_\_\_\_

\_\_\_\_\_

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## AUTHORIZATION FOR REPRESENTATIVE PAYEE SERVICES

Social Security Administration has determined that assistance is needed in managing my benefits. This means that my benefits will be sent to representative payee to provide assistance that will be responsible for managing my benefits in my best interest under the guidelines of Social Security Administration.

I \_\_\_\_\_ (\_\_\_ Client \_\_\_ Guardian \_\_\_ Legal Representative), hereby authorize A1 Payee Services authorization to file an application to serve as my representative payee. I understand that this means that A1 Payee Services will receive my monthly (SSA or SSI) benefit from Social Security Administration.

I understand that I have the right to appeal any decision regarding selection of representative payee with the Social Security Administration.

I understand that it's my responsibility to contact the Social Security Administration directly at any social security office to appeal my decision. I must submit my appeal within 60 days. If I decide to appeal my decision, I must submit written request to review information in my file.

Client/Parent/Guardian/Representative Signature

Date

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**Emergency Contact:**

Name: \_\_\_\_\_ Phone #: \_\_\_\_\_

Relationship: \_\_\_\_\_

**Case Manager:**

Name: \_\_\_\_\_ Phone #: \_\_\_\_\_

Agency: \_\_\_\_\_

**MONTHLY INCOME:**

\_\_\_ SSI \_\_\_ SSDI \_\_\_ VA Benefits \_\_\_ Other/Specify: \_\_\_\_\_

**TOTAL MONTHLY INCOME:** \$ \_\_\_\_\_

Diagnosis: 1. \_\_\_\_\_ 2. \_\_\_\_\_ 3. \_\_\_\_\_

4. \_\_\_\_\_ 5. \_\_\_\_\_ 6. \_\_\_\_\_

**Living Arrangements:**

\_\_\_ Lives Alone \_\_\_ Lives with relative \_\_\_ Lives in family care home/Assisted Living

\_\_\_ Lives in group home \_\_\_ Lives in shelter \_\_\_ Lives in public institution

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**CLIENT MONTHLY BILLS WORKSHEET**

Please indicate below whether bills are for Rent, Electricity, Home, or Cell Phone, Cable Satellite etc. If you have more than 5 bills, please make a copy of this page to continue as page two of bills.

1. (Example) **Rent** \_\_\_\_\_ Amount: \$ 250.00 Phone #: (Landlord's phone number)

Payment: \_\_\_ Weekly \_\_\_ Bi-weekly \_\_\_ Monthly X Quarterly \_\_\_ Annually

Payable to: (Who rent is paid to) \_\_\_\_\_ Acct # (enter acct# or apartment address)

Mail Payment to: (Address where check should be mailed) \_\_\_\_\_

1. \_\_\_\_\_ Amount: \$ \_\_\_\_\_ Phone #: \_\_\_\_\_

Payment: \_\_\_ Weekly \_\_\_ Bi-weekly \_\_\_ Monthly \_\_\_ Quarterly \_\_\_ Annually

Payable to: \_\_\_\_\_ Acct # \_\_\_\_\_

Mail Payment to: \_\_\_\_\_

2. \_\_\_\_\_ Amount: \$ \_\_\_\_\_ Phone #: \_\_\_\_\_

Payment: \_\_\_ Weekly \_\_\_ Bi-weekly \_\_\_ Monthly \_\_\_ Quarterly \_\_\_ Annually

Payable to: \_\_\_\_\_ Acct # \_\_\_\_\_

Mail Payment to: \_\_\_\_\_

3. \_\_\_\_\_ Amount: \$ \_\_\_\_\_ Phone #: \_\_\_\_\_

Payment: \_\_\_ Weekly \_\_\_ Bi-weekly \_\_\_ Monthly \_\_\_ Quarterly \_\_\_ Annually

Payable to: \_\_\_\_\_ Acct # \_\_\_\_\_

Mail Payment to: \_\_\_\_\_

4. \_\_\_\_\_ Amount: \$ \_\_\_\_\_ Phone #: \_\_\_\_\_

Payment: \_\_\_ Weekly \_\_\_ Bi-weekly \_\_\_ Monthly \_\_\_ Quarterly \_\_\_ Annually

Payable to: \_\_\_\_\_ Acct # \_\_\_\_\_

Mail Payment to: \_\_\_\_\_

5. \_\_\_\_\_ Amount: \$ \_\_\_\_\_ Phone #: \_\_\_\_\_

Payment: \_\_\_ Weekly \_\_\_ Bi-weekly \_\_\_ Monthly \_\_\_ Quarterly \_\_\_ Annually

Payable to: \_\_\_\_\_ Acct # \_\_\_\_\_

Mail Payment to: \_\_\_\_\_

If you have more than 5 bills, please make a copy of this page to continue.

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## PROGRAM REQUIREMENTS

In order for A1 Payee Services to provide representative payee services, I agree to following terms, and will provide the following information:

\_\_\_ A signed release form that will allow A1 Payee Services to receive my monthly bills to assure my basic needs are met.

\_\_\_ I will provide a recent copy of my utility bills if possible.

\_\_\_ I will provide copies of the pages of my current housing lease agreement, or a reasonable statement, that show the rental amount, who checks are made out to, and mailing address. (apartment, group home, family care, assisted living, hand written and dated agreement, etc.)  
**(Not the entire lease)**

\_\_\_ I will provide a copy of my current state identification card and Social Security identity card.

\_\_\_ I will provide a copy of my current guardianship ward/or legal representative information signed by the court/ with seal if applicable.

\_\_\_ A copy of the physicians statement, and/or FL-2(adult care), and/or other documents specifying a client's current diagnosis **if applicable.**

\_\_\_ If there are any changes in housing, marital status, guardianship/legal representative and/or my monthly expenditures, A1 Payee Services must be notified within 30 days of change status.

\_\_\_ I will keep all scheduled appointments with A1 Payee Services regarding updates on payee account (client, parent, guardian, or representative).

\_\_\_ I understand that in order for A1 Payee Services to provide payee services, Social Security Administration allows a representative payee to collect a fee for providing payee services. The fees are set by Social Security Administration, and presently are \$42.00 for individuals, or up to \$80.00 from beneficiaries entitled to disability benefits that have a drug addiction and/or alcoholism condition, but can be no more than 10% of monthly income.

\_\_\_ I understand that if A1 Payee Services is no longer acting as my representative payee, or the client has expired, any funds remaining in the client's account will be returned to Social Security Administration.

Signature of Client:

Date:

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