A1 PAYEE SERVICES
PO Box 3562
Durham, NC. 27702-3562
Phone: (919) 323-8113
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.

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: _____

Legal Guardian Contact:

Name: _____ Phone #: _____

Address: _____

Date of & Reason for appointment : _____

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 Checklist

To allow 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. (Pages 2 & 3 of this package)

___I will provide a recent copy of my utility and/or other bills listed on the monthly bills worksheet 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. (Please include with application if possible)

___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 $45.00 for individuals, or up to $84.00 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:

_____ _____