Generations Family Service(GFS)

-501 (C) 3 bonded Non-Profit-

FACE SHEET/ REFERRAL: **Date: _____**

Rep Payee/VA Fiduciary/SOAR

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Daytime Phone #: _____ Evening #: _____

Date of Birth: _____ Social Security #: _____

Marital Status: ____Married ____Single ____Divorced

Employment: ____Employed ____Unemployed ____Retired

Current Payee & Phone #: _____

Mother's Maiden Name: _____ Father's Names: _____

Client's Place of Birth (City & State): _____

Emergency Contact: (Name Phone # & Relationship to you):

_____

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:

Alone: _____ Roommate: _____ Family: _____ Group Home: _____ Family Care Home:_____

Assisted Living: _____ Shelter: _____ Institution:_____

Signature: _____ Date: _____

Phone: (919)602-3983, Fax: (844)331-2861
Generationsfamilyservices.org or generationsfamilyservices@outlook.com

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Voluntary Consent/Authorization & Request for Change of Payee Application

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

I understand and agree with the following:

Need for Representative Payee

The Social Security Administration (SSA) has determined 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

I VOLUNTARILY, select Generations Family Services, Inc. to serve as my SSA representative payee.

_____, I acknowledge that **I DO NOT HAVE** anyone else such as (FAMILY MEMBER or FRIEND) that can serve as my SSA representative payee.

_____, I acknowledge that I was voluntarily referred to or contacted Generations Family Services for payee services.

_____, I understand, and am fully aware, that Generations Family Services charges a **standard monthly fee** for SSA representative payee services.

_____, I agree to payment of a **standard monthly fee** to Generations Family Services for the SSA representative payee services provided.

AUTHORIZATION

I _____hereby give GFS (GFS) my authorization to file an application to be my organizational representative payee.

I understand that the Social Security Administration (SSA) will send my SSI and/or SSA benefits directly to GFS to administer for me. I understand that it is the responsibility of my representative payee (GFS) 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.

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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 my representative payee, and, 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 my file and submit new evidence if necessary. I understand that I can have a friend, lawyer or someone else to help me.

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

I hereby acknowledge that this consent is truly voluntary, and it has been explained to me that GFS is working as fee for service business and will collect a monthly fee (set by the Social Security Administration) from my benefit check.

_____ _____

Client/Parent/Guardian/Representative Signature Date

_____ _____

Witness Date

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CONSENT TO GFS PROGRAM REQUIREMENTS

In order for GFS to provide representative payee services, I agree to the following terms and conditions and will provide the following information:

- ☐ A signed release form which will allow GFS to receive my monthly bills to assure my basic needs are met.
- ☐ I will provide a copy of my current housing lease agreement (apartment, group home, family care, assisted living, etc.), and report changes to my housing arrangements immediately to GFS.
- ☐ I will provide my landlord 30-day notice prior to moving out
- ☐ I will provide a copy of my current guardianship ward/or legal representative information/ signed by the court/ with seal.
- ☐ A copy of FL-2 /or other documents specifying a client's current diagnosis.
- ☐ Any changes in housing, marital status, guardianship/legal representative and my monthly expenditures, GFS must be notified within 30 days of change status.
- ☐ I will keep all scheduled appointments with GFS regarding updates on payee account (client, parent, guardian, or representative).
- ☐ I understand that in order for GFS to provide payee services, Social Security Administration allows a representative payee to collect a fee for providing payee services.

Representative payee fees for 2018 are set as
$_____ or
$_____ for substance abuse clients

- ☐ I understand that if GFS 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.

_____ _____
Client/Parent/Guardian/Representative Signature Date

_____ _____
Witness Date

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AUTHORIZATION TO OBTAIN PERSONAL & HEALTH CARE INFORMATION

I, the Client/Consumer/Parent/Guardian of:

Client Name: _____ SSN: _____ DOB:_____

Authorize GFS Representative Payee Services and its employees to obtain the following information/records:

___Educational	___Social	___Wages Information
___Medical/Dental	___Vocational	___Psychological
___Individual Program Plan	___Utility Bills	___ Other(Specify):

_____

This information will be used for the purposes indicated below:

___Social Security Eligibility	___Social Security Re-determination
___Paying My Bills	___Other (Specify):

_____

This authorization will remain in effect for as long as I am a client with GFS Representative Payee Services or until revoke by me in writing.

_____ _____

Client/Parent/Guardian/Representative Signature Date

_____ _____

Witness Date

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AUTHORIZATION FOR RELEASE/EXCHANGE OF INFORMATON

Client Name:_____ DOB:_____ Social Security#:_____

I authorize _____ to exchange specified protected information on the above name client.

Address: _____

City: _____ State:_____ Zip: _____

This information may include (Check all that apply)

☐ Psychiatric Evaluation ☐ Service Plans

☐ Psychological Evaluation ☐ Medication History

☐ Medication Evaluation ☐ HIV, AIDS or AIDS related information

☐ Progress Notes ☐ Financial Information

☐ Verbal Exchange of Information ☐ FL-2/MR-2

☐ Substance Abuse Evaluation (evaluations, reports)

I understand that this information will be used for:

☐ Budget ☐ Planning Treatment Planning ☐ Billing/Payment/Collections

_____ _____

Client/Parent/Guardian/Representative Signature Date

_____ _____

Witness Date

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CLIENT MONTHLY BILLS WORKSHEET

(Please indicate below whether bills are for Rent, Electricity, Cell Phone, Cable/Satellite etc.)

RENT/LANDLORD:

Name: _____

Address:_____

Contact: _____ Telephone: _____ Account #:_____

DUE Date: _____ AMOUNT $:_____

UTILITY (Electricity):

Name: _____

Address:_____

Contact: _____ Telephone : _____ Account #:_____

DUE Date: _____ AMOUNT $:_____

UTILITY (Gas):

Name: _____

Address:_____

Contact: _____ Telephone: _____ Account #:_____

DUE Date: _____ AMOUNT $:_____

PHONE/CELL:

Name: _____

Address:_____

Contact: _____ Telephone: _____ Account #:_____

DUE Date: _____ AMOUNT $:_____

CABLE/SAT TV:

Name: _____

Address:_____

Contact: _____ Telephone: _____ Account #:_____

DUE Date: _____ AMOUNT $:_____

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CLIENT MONTHLY BILLS WORKSHEET continued…

(Please indicate below whether bills are for Rent, Electricity, Cell Phone, Cable/Satellite etc.)

FOOD:

Name: _____

Address:_____

Contact: _____ Account #:_____

DUE Date: _____ AMOUNT $:_____

MEDICATION CO-PAYS:

Name: _____

Address:_____

Contact: _____ Account #:_____

DUE Date: _____ AMOUNT $:_____

OTHERS:

Name: _____

Address:_____

Contact: _____ Account #:_____

DUE Date: _____ AMOUNT $:_____

OTHERS:

Name: _____

Address:_____

Contact: _____ Account #:_____

DUE Date: _____ AMOUNT $:_____

OTHERS:

Name: _____

Address:_____

Contact: _____ Account #:_____

DUE Date: _____ AMOUNT $:_____

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RELOADABLE DEBIT CARD CONSENT FOR RELEASE OF INFORMATION

Client Name: _____ Social Security #:_____

I authorize GFS as my (Representative Payee/Bill Pay/Fiduciary) to order and set a **Reloadable Debit Card** in my name as a secure measure to receive monthly funding once all of my bills and financial responsibilities has been met. I understand that I am limited to the funds place on my card once a month. I take full responsibility for this card and will ensure that it is kept in a save place at all times.

Individual/Organization: RELOADABLE DEBIT CARD

Address:_____

City/State:_____

Zip:_____

I understand that authorizing the request/disclose of information in my records is voluntary, and that my services will not be affect if I choose not sign this form.

I understand that any release/disclosure of information carries with it the potential for unauthorized re-disclosure and the information may not be protected by federal confidentiality laws. Authorize re-disclosure may be allowed by law.

This authorization except for action already taken can be revoked at any time by submitting a written request notice to GFS.

_____ _____

Client/Parent/Guardian/Representative Signature Date

_____ _____

Witness Date

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GFS STANDARD OF PRACTICES

Welcome to Generations Family Services (GFS), as your representative payee we look forwarding to working with you and ensuring that your bills are paid in a timely manner and your basic needs appropriately met. The information enclosed is to provide guidance and understanding of what you should expect from GFS.

According to the Social Security Administration as your representative payee, GFS duties are as follows:

- With your assistance identify and determine your needs and use your benefit payments to meet those needs:
    - Shelter: (rent, utilities, water, cable, phone, gas etc.).
    - Food, clothing, medical care, co-pays etc.
    - And provide you with personal funds
- Save any money left after meeting your current needs
- Report any changes or events which could affect your eligibility for benefits or payment;
- All employment income must be reported to the Social Security Administration by the Rep Payee; it is the beneficiary's responsibility to provide income information to the payee in a timely manner.
- Keep records of all payments received and how you spent and saved them;
- Provide benefit information to social service agencies or medical facilities that serve you
- Help you get medical treatment when needed;
- Complete written reports accounting for your use of funds; and
- Return to SSA any payments to which you're not entitled

POLICIES AND PROCEDURES:

1. Office hours: 9am-4pm Monday through Thursday and 9am-12pm on Fridays
2. Questions and/or concerns can be directed to GFS during office hours
3. All phone messages detailing reasons for call and email correspondence will be returned within 24 hours of receipt
4. Upon receipt of your benefits, GFS will work hard to ensure that your rent is paid between the 1st (first) and the 5th (fifth) of the month, to avoid late fees imposed by landlord
5. All bills are paid upon receipt of statements and invoices by GFS
6. **24 hours' notice is required for request of funds**
7. Payments are scheduled based on the availability of your personal funds on:

Wednesdays and or 3rd or 15th of the month

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8. Requesting 'extra' money is not an emergency.
9. ***No checks are processed and mailed out on the same day they are requested, and no checks are available for pick up at the office by clients, guardian, social worker and or case managers.
10. If a need arises, GFS will complete the request within (24 hours), two days unless it is an emergency.
11. Emergency is defined as: death, rent deposit, lack of food, unexpected medical services. Other exceptions will be decided at the discretion of GFS as they arise.
12. Requests for amounts over $100 require a detailed receipt for Social Security purposes.
13. All clients are encouraged to set up a bank account (checking/savings), or obtain a **re-loadable debit card** as desired, so that you can get your personal funds faster and avoid waiting for your check in the mail.
14. **GFS HOLDS NO RESPONSIBILITY** for ordering or obtaining re-loadable debit cards for clients
15. Client holds full responsibility for checking/saving account and or re-loadable debit cards, lost or stolen.
16. Direct Deposit for checking/saving and re-loadable debit cards must be called in/faxed over to GFS to set up direct deposit
17. All checking/savings account and re-loadable debit cards will undergo a 5-day verification process through the bank once entered. No payments will be released to the card until approved by the bank
18. All employment income must be reported to the Social Security Administration by the Rep Payee; it is the beneficiary's responsibility to provide income verification to the payee in a timely manner.
19. Rent changes must be reported immediately to GFS or no later than 15th of current month, prior to entering the new month.
20. Clients are fully responsible for all fees incurred resulting from late notice of rental changes.
21. All bills must be sent directly to GFS for payment.
22. Clients are fully responsible for making the necessary address changes with vendors: (Utility, Cable, Cable, Phone and etc.) in order to ensure receipt of bills by GFS

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REMINDERS: (Payment Schedule)

- **ALL detailed phone messages and or emails are returned within 24 hours**

- **DEPOSITS ON RE-LOADABLE CARDS AND CHECKS ARE ISSUED ON WEDNESDAY**
- EMERGENCIES are defined as but not limited to:

    a. Death of family member (obituary/notice of death required)
    b. Rental deposit
    c. Additional food needed
    d. Unexpected medical services

23. Additional fees may be charged for communication with Bail Bondsman
24. Accounting Reports- are printed and mailed upon request
25. Emergency Hotel stay requires the hotel to email/fax over a third-party payor notice, which will be completed within 24 hours on your behave upon verification of your account balance.

GFS looks forward to working with you so please do not hesitate to call us with any questions or concerns regarding this notice @ (919)602-3983 or (800)437-1695.

_____ _____

Client/Parent/Guardian/Representative Signature Date

_____ _____

Witness Date

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