

# **GENERATIONS FAMILY SERVICE(GFS)**

-501 (C) 3 bonded Non-Profit-

## **Disclaimer:**

**PLEASE BE ADVISED THAT ALL CLIENTS MUST HAVE ACCESS TO SOME FORM OF DIRECT DEPOSIT VIA CHECKING /RELOADABLE DEBIT CARD/SAVINGS ACCOUNT. DIRECT DEPOSIT INFORMATION MUST BE PROVIDED IN ORDER TO SCHEDULE PERSONAL FUNDS. PERSONAL FUNDS PAYMENTS WILL ONLY BE ISSUED VIA DIRECT DEPOSIT**

**I \_\_\_\_\_ client/legal guardian understand and acknowledge that personal funds will only be scheduled and issued via direct deposit. It is my responsibility to ensure that GFS is provided with direct deposit information upon completion of paperwork.**

\_\_\_\_\_  
**Client/legal guardian signature.**

\_\_\_\_\_  
**Date**

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**FACE SHEET/ REFERRAL:**

**Date:** \_\_\_\_\_

## Rep Payee

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):  
\_\_\_\_\_

Legal Guardian/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: \_\_\_\_\_

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Signature: \_\_\_\_\_ Date: \_\_\_\_\_

## Voluntary Consent/Authorization & Request for Change of Payee Application

Name of Wage Earner, Self-Employed Person or Claimant Social Security Number

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

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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 2021 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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## 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 1<sup>st</sup> (first) and the 5<sup>th</sup> (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 3<sup>rd</sup> or 15<sup>th</sup> 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 \$200 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 15<sup>th</sup> 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

Phone: (800)437-1695, Fax: (844)331-2861

Generationsfamilyservices.org or SSA1@generationsfamilyservices.org

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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 behalf 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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## **GFS PROGRAM EXPECTATION/REQUIREMENTS**

### **Clients:**

- GFS pays all clients and vendors by check or direct deposit only.
- GFS DOES NOT send money orders, certified bank checks, or make online payments of any kind.

### **Purchase of Client Goods & Services:**

- GFS will coordinate payment to vendors upon receipt of a bill or proposal for services to be rendered.
- In emergency situations where client is in need of goods quickly, the vendor may fax us a bill for payment and, if client funds allow, we will issue a check to the vendor the same day.
- GFS will not order goods and/or services for clients
- GFS will not pick up or transport medication, clothing, etc. to clients.
- The responsibility of securing goods and services, as well as picking up medication/clothing/goods for transport to the client falls within the purview of the client's case management team and/or guardian.
- GFS does not order or pay for client goods/services online.

### **Utilities:**

- GFS does not initiate, terminate, change or reinstate client services for utilities or cable/internet vendors as those accounts do not belong to us.
- GFS is responsible for payment of services in a timely manner upon receipt of a bill before it is due.
- It is the responsibility of the client/case manager/guardian to confirm with all vendors that bills to be paid are mailed to GFS monthly/quarterly, etc.
- Bills received by GFS will be paid if funds allow.
- GFS will not seek out bills or call for balances due.
- GFS is not responsible for the consequences of late bills received that result in disconnection or interruption of services.

### **Client Housing:**

- It is not GFS responsibility to secure client housing or placement.
- GFS works with many landlords and facilities and, upon request, is able to provide clients with information from our resource listing to secure housing on their own.
- Upon receipt of appropriate contact and rent information provided by the client/case manager/guardian, GFS will contact the landlord or facility to coordinate payment of client rent.

### **Reloadable Debit Cards:**

- GFS will not secure debit cards or bank accounts for any clients.

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- The responsibility for securing a reloadable card or opening a checking/savings account for direct deposit falls to client/case manager/guardian.
- Once a card is secured, it must be activated and the account/routing numbers must be submitted to GFS to enter into our bank for approval.
- Once approved by our bank, GFS can then send funds by direct deposit.
- If there are any issues with debit cards or bank accounts (fees, overdrafts, account closures, etc. ) it is the client's responsibility to contact customer service or the bank associated with that card to address any issues they are experiencing.
- Clients debit cards/accounts do not belong to GFS, nor do GFS have anything to do with them outside of loading funds.
- If a client has overdraft protection on their card/account, and they overdraft funds, GFS is not responsible to pay the balance due.
- Overdraft payment depends upon availability of client funds.
- Therefore, GFS encourages all clients to remove that protection from their account.

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Client/Parent/Guardian/Representative Signature

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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):

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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)

- |  |  |
|--|--|
| <input type="checkbox"/> Psychiatric Evaluation                            | <input type="checkbox"/> Service Plans                         |
| <input type="checkbox"/> Psychological Evaluation                          | <input type="checkbox"/> Medication History                    |
| <input type="checkbox"/> Medication Evaluation                             | <input type="checkbox"/> HIV, AIDS or AIDS related information |
| <input type="checkbox"/> Progress Notes                                    | <input type="checkbox"/> Financial Information                 |
| <input type="checkbox"/> Verbal Exchange of Information                    | <input type="checkbox"/> FL-2/MR-2                             |
| <input type="checkbox"/> Substance Abuse Evaluation (evaluations, reports) |  |

I understand that this information will be used for:

- |                                 |  |  |
|---------------------------------|--|--|
| <input type="checkbox"/> Budget | <input type="checkbox"/> Planning Treatment Planning | <input type="checkbox"/> Billing/Payment/Collections |
|---------------------------------|--|--|

\_\_\_\_\_  
Client/Parent/Guardian/Representative Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Date

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## CLIENT MONTHLY BILLS WORKSHEET

**A copy of client's bills must be attached with intake form in order to be processed**

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

### RENT/LANDLORD:

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

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

Contact: \_\_\_\_\_ Phone: \_\_\_\_\_ Account #: \_\_\_\_\_

DUE Date: \_\_\_\_\_ AMOUNT \$: \_\_\_\_\_

### UTILITY (Electricity):

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

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

Contact: \_\_\_\_\_ Account #: \_\_\_\_\_

DUE Date: \_\_\_\_\_ AMOUNT \$: \_\_\_\_\_

### UTILITY (Gas):

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

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

Contact: \_\_\_\_\_ Account #: \_\_\_\_\_

DUE Date: \_\_\_\_\_ AMOUNT \$: \_\_\_\_\_

### PHONE/CELL:

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

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

Contact: \_\_\_\_\_ Account #: \_\_\_\_\_

DUE Date: \_\_\_\_\_ AMOUNT \$: \_\_\_\_\_

### CABLE/SAT TV:

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

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

Contact: \_\_\_\_\_ 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 \$: \_\_\_\_\_