Best Payments Foundation

New Client Application

Personal Information **Today's Date** _____

First Name _____ Last Name _____

Date of Birth _____ Social Security Number _____

Current Address _____

City _____ State _____ Zip _____

Phone # _____ H / C County _____

Place of Birth (City / State) _____

Year Graduated High School _____ Do you have a valid driver's licenses? YES NO

Type of Service Being Requested

☐ Payee Services ☐ JFS Auth Rep ☐ Benefits Consultation ☐ Supported Employment

Guardian Information – Please attached a copy of the guardianship paperwork.

Name (s) _____

Address _____ City _____

State _____ Zip _____ Phone # _____

Email _____

Support Administrator / Case Manager / Agency Information

SA / Case Manager / Support Person Name _____

Agency Name _____ Phone # _____

Email _____

New Client Application (Page 2)

Income / Assistance Information

☐ Social Security ☐ Employment ☐ Other _____

Currently Receiving the Following Benefits? ☐ Social Security Income ☐ Social Security Disability

☐ Food Stamps ☐ Medicaid ☐ Medicare ☐ Other _____

☐ Rent Subsidy Amount and From What Agency / Organization? _____

Employer Name _____ Address _____

Employer Contact Name _____ Phone Number _____

Do you have any of the following?

☐ Burial Fund ☐ Stocks & Bonds ☐ Trust Fund ☐ Life Insurance Policy

Do you have a Vehicle in Your Name? Make, Model and Year _____

For Payee Services Please complete this section for us to be your Payee.

Reason for Payeeship _____

Do You Currently have a Payee? YES NO If YES, please completed the following

Company Name _____ Contact Name _____

Phone # _____ Email _____

For Authorized JFS Representative Services You must also complete JFS 06723 Form.

Reason JFS Auth Rep is Required _____

Current JFS Auth Rep _____ Phone # _____

Email _____

For Benefits Consultation Only – Please complete the following section

Has Client Ever Received SS Benefits? No Yes When Did Benefits Stop _____

Has the Client Ever Been Denied for SS Benefits? No Yes When _____

For Supported Employment Only – Please complete the following section

Employer _____ Position _____

www.bestpayments.net

info@bestpayments.net

(740) 263-7970 Office
(740) 879-2914 Fax

New Client Application (Page 3)

As a client of Best Payments, you have the right to:

1. To participate in creating a budget to ensure your housing, utilities and basic daily needs are met.
2. To be treated with respect
3. To be fully informed of your rights and receive a copy of anything we ask you to sign

As a client of Best Payments, you have the responsibility to:

1. Provide accurate information to Best Payments
2. To notify Best Payments of any changes regarding income, expenses, living arrangements and employment.
3. To follow your budget
4. To treat Best Payments employees with respect

Authorization for Services

As a client of Best Payments, I agree to the following Authorization for Services:

1. I understand that Best Payments has filed an application with The Social Security Administration to become my representative payee and / or an application with Ohio Department Job and Family Services to become my JFS Authorized Representative

2. I understand Best Payments will receive any Social Security benefits that I am eligible for. Best Payments will be responsible of managing my benefits in my best interest and follow Social Security guidelines for managing my money. I understand that I have a budget and I will have access to my money as outlined in my budget.

3. I understand this is a voluntary program and can be terminated at any time by either party for any reason.

4. I understand Best Payments may release information as permitted by law.

5. I am aware this is a fee for service program. The monthly fee(s)will be deducted from my payee account. I am responsible for the monthly fee(s) unless the following agency / provider pays the monthly fee(s) _____ (Insert Agency Name)
   a. Monthly Rate for Payee Services is $41.00 per month.
   b. Monthly Rate for JFS Authorized Rep Services is $15.00 month.

_____ _____

New Client Application Completed By (Print Name) Date

_____ _____

Signature Your Phone Number

www.bestpayments.net

info@bestpayments.net

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Ohio Department of Job and Family Services

DESIGNATION OF AUTHORIZED REPRESENTATIVE

First Name of Applicant/Recipient	MI	Last Name		Medicaid billing # or SSN
Street Address, including Apt. #		City	Zip	County

I hereby authorize the following person or company to act as my representative:

First Name	MI	Last Name		Home Phone	
Title	Company			Work Phone	
Mailing Address		City		State	Zip

I authorize this person or company to represent me regarding:

☐ Food Assistance ☐ Cash Assistance ☐ Medicaid ☐ Child Care

This authority lasts until:

☐ My application has been approved
☐ I rescind this authority, or appoint a new representative
☐ Other (please specify a date or action) _____

I authorize this person or company to do the following on my behalf:

☐ Take any action that may be needed to ensure that I receive or continue to receive the benefits indicated above

OR only the specific actions selected below

☐ Present my application for benefits
☐ Provide verifications to the CDJFS on my behalf
☐ Receive and respond to copies of all correspondence regarding my application
☐ Represent me at a state hearing
☐ Collect my medical records
☐ Other (please specify) _____

_____

While this authorization is in effect, all notices sent by the County Department of Job & Family Services or the Ohio Department of Job & Family Services will also be sent to your authorized representative.

Signatures. This form has no effect unless signed by the person granting authority and by the authorized representative or an employee of the company appointed to be the authorized representative.

Signature of Person Granting Authority		Date
Signature of Authorized Representative	Title *(if employee of authorized company)*	Date