Client Intake Packet

AllTrust
Payee Corp., Inc.

Personal Information

Name:	**Date of Birth:**
Place of Birth:	**Age:**
Mothers Maiden Name:	**SSN:**
Address	**Phone:**
City, State, Zip	**Marital Status:**
Driver License or State ID Number:	

Do you live alone? ◯ **Yes** ◯ **No** **If "No" Please provide the names below of those you live with.**	**Living Arrangement:** ◯ **House** ◯ **Apartment** ◯ **Assisted Living** ◯ **Board &Care** ◯ **SRT** ◯ **Group Home** ◯ **Homeless** **IF LIVING IN AN ASSITED LIVING FACILIY THE NAME OF THE FACILITY AND EXACT MOVE IN DATE IS REQUIRED BY SOCIAL SECURITY.**
	Other:

Assisted Living Facility:	***Move in Date:***
Name of household member:	**Relationship:**
Name of household member:	**Relationship:**
If you have recently moved, please provide your previous address.	

Landlord / Mortgage Information

Landlord Name:	**Phone:**
Address:	**Rent Amount:**
City, State, Zip	**Date Due:**
Is the client, or anyone living at the residence, related to the landlord? ◯ **Yes** ◯ **No**	

A copy of the Lease or Contract is required before any rent payments can be made.

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Case Management Services

Do you currently receive case management services? ◯ Yes ◯ No	Name of Agency:
Name of Case Manager:	Office Phone:
Case Manager Email:	Cell Phone:

Emergency Contacts

Full Name	Phone	Relationship
Full Name	Phone	Relationship

Benefits (Please list the amounts)

SSI:	SSD:	VA:
Food Stamps:	Gov. Rental Assitance:	Other:

Asset Information

Do you own a vehicle?	Make/Model:	Year:
Date Purchased:	Balance Owed:	Car Payment:
Insurance Company:		Phone:
Address:		Amount of premium:
		Due Date:

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Signatures

I affirm that all information provided is true and up to date. I also understand that is it my responsibility to make sure that AllTrust Payee has complete and accurate information on my record at all times. **I further understand that AllTrust Payee is a Fee-For-Service organizational Payee authorized by SSA to collect a monthly fee.**	
» Client Signature:	**» Date:**

I agree that Alltrust Payee may discuss my case information with my case management service, and vendors regarding my bills and any other agency deemed necessary to ensure proper maintenance of my finances.	
» Client Signature:	**» Date:**
» Representative Payee Signature:	**» Date:**

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Client Name: _____

PLEASE make sure to have the mailing address switched over to AllTrust immediately. If AllTrust does not receive bills directly, then we cannot be held accountable for any late payments and fees.

Estimated Budget Worksheet

Type	Amount	Date	Vendor Name/Address
Rent			
Phone Internet Cable			
Electricity			
Gas			
Water			
Payee Fee			
Other			

After budget approval, AllTrust will ultimately determine personal spending to fit each individual's budget.

Total: _____

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Client Contract

I, _____ hereby appoint AllTrust Payee Corp., to be my designated Representative Payee for my Social Security Benefits, Veterans Benefits, or any other income I may have. AllTrust Payee Corp., Inc will report to SSA any events that may affect my eligibility for payments. AllTrust Payee Corp., Inc. will be accountable to SSA for all funds spent on my behalf.

By initialing below I declare that I have read and understand all the requirements and what is to expect when becoming a beneficiary through AllTrust Payee Corp., Inc.

_____ AllTrust Payee Corp., Inc is obligated by Social Security Administration and/or Veterans Administration to use your benefits for (1) Rent (2) Utilities (3) Food and (4) medical, primarily. **THESE ITEMS MUST BE ATTENDED TO FIRST**. If there are any remaining funds after these have been met, AllTrust will assist you in preparing a budget for other expenses and needs.

_____ If at any time you become homeless or in a shelter, AllTrust Payee will set aside 25% of your benefit check each month for housing purposes making sure not to exceed the amount allowed by Social Security Administration.

_____ ALL bills must be mailed directly to AllTrust Payee Corp., Inc. to ensure they are paid on time and avoid late fees. We do not pay any bills without being provided with an invoice.

_____ AllTrust Payee Internal policies regarding your money: (1) We **do not** write undesignated check for over $100.00 directly to the client (2) We do not pay for tattoos, the purchase of smartphones, or massages (unless medically prescribed).

_____ When you receive a personal spending check, you are required to provide receipts or sign a personal needs receipt stating what you are using the funds for. **This is a Social Security Administration Requirement.**

_____ AllTrust Payee Corp., Inc will charge a monthly fee of _____ for their services. There will be an annual rate increase as determined by Social Security. Per SSA regulations, additional bank service charges and fees may apply as applicable. **A balance of $10.00 must remain in your account at all times.**

_____ In the event of change in payee, AllTrust Payee Corp., Inc. will return any conserved funds to the Social Security Administration.

_____ _____

Client Signature Date

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RELEASE OF INFORMATION

I, the undersigned do hereby request and authorize the release of information requested below from the records of:

Name_____ D.O.B _____SS# _____

By initialing the spaces below, I hereby authorize AllTrust Payee Corp., Inc to obtain and/or exchange information with the following individuals and/or agencies for the purpose of planning for my well-being and/or assuring my continuing eligibility for Social benefits.

_____ Physicians, Psychiatrists, and/or Counselors _____Diagnosis _____ Medications _____ Behavior
_____* Case Managers, Community Support Agencies, and/or Caretakers
_____* Utility/Vendors (including, but not limited to: Insurance Agents, Landlords, and or any other provider/bill collection agency)
_____* I authorize AllTrust Payee Corp., Inc. to access my utility/vendor account information and update as needed.
_____ *Social Security Administration
_____ Specific names of individuals that provide support: (list below)
_____

By initialing the spaces below, I declare that I have examined all information on this form and that it is true and correct to best of my knowledge.

_____*I understand that AllTrust Payee Corp., Inc. is not responsible if a person/agency authorized to obtain information regarding my account does so with false pretenses.
_____*I understand that AllTrust Payee Corp., Inc. is not responsible for any effect to my benefits caused by releasing information.
_____*I understand that I may revoke this consent at any time by providing written notification of my intent to do so to AllTrust Payee. I understand that this does not apply to information that has already been disclosed.

(Items marked with * are mandatory for program participation)

This release is effective during your service period with AllTrust Payee Corp., Inc. This release will remain effective until 30 days after termination

_____ _____

Signature of Applicant or Parent/Guardian Date

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Please provide a photocopy a Driver's License and or State ID.
The Advanced Notification Form must be completed with this packet.
Incomplete packets will not be accepted by AllTrust and will delay the process of a client becoming active.

Thank you