Representative Payee Services

Client Intake Packet

ALLTRUST PAYEE CORP., INC.
2046 Treasure Coast Plaza, Suite A294
Vero Beach, FL 32960
772-226-0165
Fax: 772-618-4647
admin@alltrustpayee.com

AllTrust Payee Corp., Inc.
2046 Treasure Coast Plaza, Suite A294
Vero Beach, FL 32960
772-226-0165

CLIENT CONTRACT

I, _____ hereby appoint AllTrust Payee Corp., Inc. to be my designated Representative Payee for my Social Security Benefits or any other income I may have.

AllTrust Payee Corp. will use funds received on my behalf to meet my current needs for shelter, food, clothing and medical care.

AllTrust Payee Corp. will report to SSA any events that may affect my eligibility for payments.

AllTrust Payee Corp. will be accountable to SSA for all funds spent on my behalf.

I grant AllTrust Payee Corp. permission to discuss my financial needs with:

_____ _____
Name Phone Number

_____ _____
Name Phone Number

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

I understand that AllTrust Payee Corp., Inc. will charge a monthly fee of _____ for their services. I understand that there will be an additional fee of _____ per month for a PNC Bank debit card. This amount will be deducted out of my account on or by the 3rd of each month. I will be given a 45 day advance written notice if this fee changes.

_____ _____
Client Signature Date

_____ _____
AlllTrust Payee Signature Date

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CLIENT INTAKE

Date: _____

LAST NAME	FIRST	MI	SOCIAL SECURITY NUMBER
DATE OF BIRTH			PLACE OF BIRTH
MOTHERS MAIDEN NAME			

THIS INFORMATION MUST BE PROVIDED OR WE CANNOT PROCESS YOUR REQUEST.

LIVING ARANGEMENT

C/O	Telephone Number
Street Address	Move In Date
City, State, Zip Code	Monthly Rent Amount

Do you live alone? _____ Yes _____ No
If no, whom do you live with?

NAME	RELATIONSHIP
NAME	RELATIONSHIP
NAME	RELATIONSHIP

Notes: _____

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Budget Worksheet

Client Name: _____ SSI (T16): _____

SSN/TRUST: _____ SSA (T2): _____

Effective Date: _____ Other: _____

TOTAL: _____

TYPE	AMOUNT	DATE/FREQUENCY	VENDOR NAME & ADDRESS
Rent			
Phone, Internet, Cable			
Electricity			
Gas			
Other/Misc			
Other/Misc			
Payee Fee			

TOTAL: _____

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Request for Payee Service

Agency: _____ Case Manager: _____

Address: _____

Phone: _____ Date of Request: _____

Client Information:

Name: _____ SSN: _____

DOB: _____ Phone: _____

Admit Date: _____ Marital Status: _____

Current or Last Known Address: _____

Contact Person: _____ Phone: _____

Living Arrangements:

____ House ____ Apartment ____ Hotel ____ Board and Care

____ Room & Board ____ Shelter ____ Homeless

Income: (Amounts): SSA: _____ SSI: _____ VA: _____ R/R: _____

AFDC: _____ Other: _____

Resources: Bank Account: _____ Vehicle: _____ House: _____

Previous Payee: _____

*If client is currently his/her own payee, a SSA-787 must be signed by an MD indicating why the client needs a payee. In lieu of a doctor's statement, the testimony of three persons familiar with the client's situation can be submitted as evidence as to why the client needs a payee. Persons can be: family members, discharge planner, social worker, treatment team staff, neighbor, B&C operator or friend.

Comments: _____

_____

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EMERGENCY CONTACTS

Name	Name
Street Address	Street Address
City/State/Zip Code	City/State/Zip Code
Telephone	Telephone
Relationship	Relationship

OTHER CONTACTS

Name	Name
Street Address	Street Address
City/State/Zip Code	City/State/Zip Code
Telephone	Telephone
Relationship	Relationship

IDENTIFICATION

GET A COPY OF THE FOLLOWING FOR FILE:

PHOTO ID	SSA CARD
MEDICARE/MEDICAID	OTHER ID

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INCARCERATION

JAIL/PRISON LOCATION: _____

DATE IN: _____ DATE OUT: _____

X-REF#: _____ CDC#: _____

PAROLE/PROBATION OFFICE NAME: _____

OFFICE TELEPHONE #: _____

SOCIAL SECURITY INFORMATION

CLAIM REP: _____ CLAIM OFFICE: _____

BENEFITS: SSI: _____ SSA: _____

OVERPAYMENT: ___YES ___ NO BALANCE: _____

RESOURCES:

_____

_____

_____

FROM OUT OF STATE: ___ YES ___ NO

DATE ENTERED STATE? _____ PROOF ON ENTRY: ___ YES ___ NO

NEW CLAIM

SSA OFFICE: _____ REP: _____

NOTES: _____

_____

_____

_____

ATTORNEY: ___ YES ___ NO NAME: _____

PHONE #: _____

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WILL/BURIAL

_____ Yes _____ No
(Get copy of this information for the file)

TYPE: _____

WHEN ESTABLISHED: _____

VALUE: _____

CONSERVED

IS THE CLAIMANT CONSERVED: _____ Yes _____ No

CONSERVATOR NAME: _____

CONSERVATOR ADDRESS: _____

_____

PHONE #: _____

MARITAL STATUS/CHILDREN

___ SINGLE
___ MARRIED(DATE:_____)
___ SEPARATED (DATE: _____)
___ DIVORCED (DATE:_____)
___ ANNULLED (DATE:_____)
___ WIDOWED(DATE:_____)

CHILDREN: ___ Yes ___ No If Yes, How Many? _____

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Consent to Release Information

To: AllTrust Payee Corp., Inc.

Name: _____ Date of Birth:_____

SSN: _____

I hereby give my consent to AllTrust Payee Corp., Inc. to obtain and/or exchange information for the purpose of either planning for my well-being and/or assuring my continuing eligibility for Social Security benefits.

I also hereby give my consent to AllTrust Payee Corp., Inc. to obtain and/or exchange information regarding the item(s) below for the purpose of planning for my well-being:

___ Social Security Number	___ Account Ledger	___ Current Monthly SSA/SSI
___ Bank Account	___ Burial Trust	___ Medicare
___ Wages/Employment Record	___ Utilities Bills	___ Address/Living Arrangement
___ O.H.S. Plan/Appointments	___ Social History	___ Other (Explain below)

_____

_____

I am the individual to whom the requested information/records applies, or the parent or legal guardian of a minor, or the legal guardian of a legally incompetent adult. I declare that I have examined all of the information on this form, and on any accompanying statements or forms, and it is true and correct to the best of my knowledge.

_____ _____
Print Name Date

_____ _____
Signature of Claimant or Legal Guardian Relationship (if not claimant)

_____ _____
AllTrust Staff Member Date

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Advance Notification of Representative Payment

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

I understand and agree with the following.

Need for Representative Payee

The Social Security Administration (SSA) has decided 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

SSA has selected ALLTRUST PAYEE CORP., INC to be my representative payee.

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

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

X _____ X _____

Signature Date

Witnesses are required only if this statement has been signed by mark (X) above. If signed by mark (X), two witnesses to the signing who know the person making the statement must sign below, giving their full addresses.

1. Signature of Witness	2. Signature of Witness
Address (Number and Street, City, State and ZIP Code)	Address (Number and Street, City, State and ZIP Code)

Form **SSA-4164** (9-1994) ef (5-2005)
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