Best Payments Foundation

New Client Application

Client Information: **Date**_____

First Name_____ Last Name_____

Date of Birth_____ Social Security Number _____

Current Address _____

City _____ State _____ Zip Code_____

Client Phone Number_____ County _____

Client Email_____

Please provide a copy of the clients ID and Birth Certificate

Type of Services Being Requested – Please check all that apply

☐ Payee Services ☐ Authorized JFS (Job and Family Services) Representative

How will Services be Paid:

☐ Self-Pay $55 monthly for payee services and $24 monthly for JFS services

☐ Bill Local County Board of DD - **Please send ISP and PAWS to ISP@bestpayments.net**

☐ Bill Money Management through I/O Waiver or Level 1 Waiver - **Please authorize 40 units of Money Management per month and email the full ISP to ISP@bestpayments.net**

Guardian Information
(Please mail the court certified guardian document to our Po Box 839 Delaware OH 43015)

Name _____

Address_____

City _____State_____ Zip _____

Phone Number phone _____

Email _____

New Client Application (Page 2)

SSA / Case Manager Information
Contact Name _____

Email _____ Phone Number _____

Provider Information
Provider Name _____

Email _____ Phone Number _____

Income/Assistance Information – check all that you CURRENTLY RECEIVE

Social Security ☐ Employment ☐ Food Stamps ☐ Medicare ☐ Medicaid ☐

Other _____

Do you receive a Rent Subsidy? ☐ Yes ☐ No
If yes, what type of rent subsidy do you receive? _____ Amount _____

Do you have a Stable Account ☐ Yes ☐ No
If yes, please provide the Stable Account Number _____

Current Employer Information

Employer Name_____

HR Contact Name _____ Phone Number _____Email _____

Living Arrangements

☐ Live Alone ☐ Live with Family (Describe) _____

☐ Have Roommates (Who are your roommates) _____

Reason for Payeeship_____

Current Payee Information
Company Name _____ Contact Name _____

Phone # _____ Email _____

For Authorized JFS Representative Services – Please complete the attached form labeled Designation of Authorized Representative. *We are NOT required to be your JFS Rep to be your payee; however, we are required to be your Authorized JFS Rep.*

Person Completing This Form
Name _____ Relationship to Client _____

Email _____ Phone Number _____

Best Payments Foundations
Intake Budget Worksheet

Personal Information	
Client Name	Social Security Number
Name of Person Completing this Form	Date

Income Section		
Type	**Monthly Amount**	**Source/ From Who?**
Social Security / SSI		
Earned Income		
Other Income		

Living Arrangements ◯ **Live Alone** ◯ **With Family** ◯ **With Roommates** ◯ **Other**

List Roommates –

Explain Living Arrangements -

Expense Section – YOU MUST PROVIDE A LEASE AND COPIES OF ALL BILLS		
Type	**Monthly Amount**	**Paid to Who / Company Name**
Rent		YOU MUST PROVIDE A COPY OF YOUR LEASE Are you currently behind on your rent? If yes, explain
Electric		
Gas		
Water		
Sewer		
Cable / Internet		
Cell Phone		
Car Payment		
Car Insurance		
Life Insurance		
Burial Funds		
Health Insurance		
Medical Payments		
Credit Cards / Loans		
Other		

Additional Information – Please answer the following questions so we can create a budget based on your individual needs and wants.
Do you smoke?
Do you currently receive food stamps? If yes, how much?
Is saving important to you? Would you like to save for Christmas or to make a large purchase? Please provide additional information.
Per Social Security guidelines, spending money will be distributed weekly. Budget permitting, amount you would like weekly for spending money?
Anything else you would like us to know when we create your budget?
Do you want Best Payments to be your Authorized JFS Representative?

Please return this completed form to
Best Payments PO Box 839 Delaware OH 43015 or info@bestpayments.net
Call 740.263.7970 with any questions

Additional Notes:

Best Payments Foundation

Employment Information

As your payee, we are required to report your job and earnings to Social Security monthly. It is your responsibility to provide this information to Best Payments. Please complete this form to ensure we are reporting information to Social Security accurately.

Please remember to let us know if your employment stops or changes.

Client Name _____

Employer Name _____

Employer Address _____ **City** _____

Employer Contact Name _____

Employer Phone Number / Email Address _____

Start Date: _____ **Hourly Rate:** _____

Expected Hours Per Week: _____

Frequency of Pay (ex. weekly, bi-weekly, daily): _____

What happens to earned income?

- ☐ **Client Keeps**
- ☐ **Direct Deposit to Best Payments payee account (We must have the employer's contact name, phone number and email to set up direct deposit information).**
- ☐ **Checks will be mailed to Best Payments (P.O. Box 839 Delaware, OH 43015)**

How will we get paystubs? We Are REQUIRED To Get Copies of Your Paystubs.

Pay Portal Information: Most companies have an online pay portal that paystubs can be retrieved from. It is much easier for us to have access to your paystubs rather than having you send them in weekly. If you have an online portal to access your paystubs, please provide the following information.

URL / Website / Link _____

Username: _____

Password: _____

- ❖ **Who is the contact for the portal's authentication code:** _____
- ❖ **Their phone number / email:** _____

If emailing paystubs in, please submit to: paystubs@bestpayments.net
If mailing in, please address it to Best Payments PO Box 839 Delaware, OH 43015.
If faxing in, our fax number is: 740-879-2914

Best Payments Foundation
Payee Service Agreement

Rights & Responsibilities

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

1. Participate in creating a budget to ensure your housing, utilities and basic daily needs are met.
2. Be treated with respect.
3. 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 and follow your budget.
2. Notify Best Payments of any changes regarding income, expenses, living arrangements and employment (start, stop or change jobs).
    a. Provide copies of your pay stubs to Best Payments.
3. Treat Best Payments employees with respect.
4. Notify Best Payments if you change payees with Social Security. You will be responsible for any bills we have paid without receiving benefits.

Authorization of 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.

2. I understand Best Payments will receive any Social Security benefits for which I am eligible. 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 payee service fee covers only responsibilities as assigned by Social Security. The monthly fee will be deducted monthly from my payee account. I am responsible for the monthly $55 fee; unless the following agency / provider pays the monthly fee _____ (Insert Agency Name)
6. Best Payments offers an optional service to be your Authorized JFS Representative. This is not a requirement of our payee service and is a separate service. If you would like Best Payments to be your JFS Representative, you understand the monthly fee of $24 will be deducted from your payee account. Please complete the Authorization of JFS Rep forms.

_____ _____
Client Name (PRINT) Date

_____ _____
Signature Social Security Number

Best Payments Foundation

JFS Authorized Representative Service Agreement

I _____ request to have Best Payments be my JFS (Job and
(PRINT YOUR NAME)

Family Services) Authorized Representative. **I authorize Best Payments to deduct $24.00 per month from my payee account for a service fee to be my JFS Authorized Representative.** The JFS Authorized Representative Services and Fees are separate and independent of any other services provided by Best Payments. Alternatively, services are to be paid from _____ (list source). I understand that if services are not paid for through this source, I am responsible for the monthly service fee. JFS Services provided by Best Payments is an optional service and can be cancelled at any time by contacting Best Payments and requesting for your JFS Services to be cancelled.

Services included with being your JFS Authorized Representative include the following items:

- Application for Medicaid and Food Assistance
- Annual Redeterminations
- Cash and Food Assistance Interim Report (happens 6 months after Annual Redetermination)
- Medicaid Annual Renewals
- Reporting Requirements
    1. Earned income
    2. Employment changes
    3. Medical changes
    4. Medical costs
    5. Household composition changes (includes moves, roommate changes and utility changes)
- Programs for Medicaid Buy In for Workers with Disabilities (MBIWD) and Medicare Premium Assistance Program (MPAP)
- Assistance with replacing EBT cards
- Liaison between client and JFS for related problems and resolution regarding JFS Services

*** Best Payments does not have the authority or ability to select or enroll anyone into a Medicaid Supplemental or Drug Prescription Plan.

Your Responsibilities are:

- To provide accurate information to Best Payments
- To notify Best Payments of any changes regarding my income, expenses, rent, living arrangements and employment.

_____ _____
Print Name Signature

_____
Address, City, State and Zip

_____ _____
Social Security Number Date

PO Box 839
Delaware OH 43015
(740) 263-7970

www.bestpayments.net

info@bestpayments.net

Ohio Department of Medicaid

Designation of Authorized Representative

Section 1 *(Please Print)*

Name of Applicant/Recipient	Medicaid Billing Number or SSN	County	
Street Address *(include Apt #)*	City	State	Zip

I hereby authorize the following person or entity to act as my representative.

This authority lasts until *(specify a date or event)*, or until it is revoked by me in writing.

Name of Representative	Title	Company
Jasmine Froehlich & Tiffany Gibbons	Payee & JFS Rep	Best Payments

Home Phone	Work Phone	Email Address
	740-263-7970	jfsdept@bestpayments.net

Mailing Address	City	State	Zip
PO Box 839	Delaware	OH	43015

I authorize my representative to do the following on my behalf:

☑ Act on my behalf in all matters with the agency ["agency" includes the County Department of Job and Family Services (CDJFS), the Ohio Department of Medicaid (ODM), and ODM's contracted designees].

OR only the specific actions selected below:

☐ Assist with my application/renewal for benefits
☐ Represent me at a state hearing
☐ Provide verifications to the CDJFS on my behalf
☐ Receive and respond to copies of all correspondence
☐ Discuss and receive information regarding my financial and medical information including protected health information (PHI)*
☐ Other *(please specify)*

***NOTE** *You must complete Section 2 of this form if this authorization is intended to allow the use or disclosure of PHI.*

While this authorization is in effect, all notices sent by the CDJFS and/or ODM will also be sent to your authorized representative.

Signatures. This form has no effect unless signed by both the person granting authority and by the authorized representative. By signing below, the authorized representative agrees to maintain the confidentiality of any information regarding the applicant/recipient provided by the agency. If the authorized representative is a provider, staff member or volunteer of an organization, then the authorized representative also agrees to adhere to the regulations cited in 42 C.F.R. 435.923(e).

Signature of Person Granting Authority *(Applicant/Recipient or Parent/Guardian)*		Date
Signature of Authorized Representative Jasmine Froehlich Tiffany Gibbons	Title *(if completing on behalf of an organization)* Best Payments Authorized JFS Rep Authorized Payee Rep	Date

Section 2

Authorization for the Use and Disclosure of Protected Health Information

Name of Applicant/Recipient	Case Number/Medicaid ID		Date of Birth
Address	**City**	**State**	**Zip Code**

The County Department of Job and Family Services (CDJFS), the Ohio Department of Medicaid (ODM) and ODM's contracted designees *(including Medicaid managed care plans)* are authorized to disclose my protected health information (PHI) to my authorized representative designated in Section 1 of this form.

I hereby authorize the use or disclosure of my protected health information (PHI) as described below.
I understand PHI can include the following types of information, and authorize its disclosure: medical records; substance abuse care; vision care; reproductive care; mental health; communicable disease; pharmacy; HIV/AIDS; dental records; and psychiatric care.

This protected health information may be disclosed:

ALL

The information is being released for the following purpose(s)

To Maintain JFS Benefits

Terms and Conditions

By signing below, I hereby authorize the disclosure of my PHI by the agency. I understand that:

- This authorization expires on the following date or event , or upon revocation by me in writing, whichever occurs first.
- I may revoke this authorization at any time. If I revoke this authorization, the revocation is not effective for the use or for the disclosure of my information that has already occurred.
- Any information used or disclosed pursuant to this authorization could be re-disclosed by the person or entity receiving the information, and will likely no longer be protected by federal privacy regulations.
- This authorization is voluntary and that I may refuse to sign it. The provision of treatment, payment, enrollment in a health plan, or eligibility for benefits cannot be conditioned on the signing of this authorization, unless the authorization is necessary for determining eligibility for the program or enrollment in the program.
- In the event my records contain psychotherapy notes, a separate authorization may be required for the release of any psychotherapy notes.
- This authorization permits the use and/or disclosure of information related to HIV testing or the treatment of AIDS or AIDS related conditions, drug or alcohol abuse, psychiatric conditions (excluding psychotherapy notes) unless specifically excluded above.

By signing below, I confirm that I have read and understand the contents of this authorization, and confirm that the contents are consistent with my direction to the entity releasing my information.

Signature of Applicant/Recipient	**Date**

If this form is signed by someone other than the Applicant/Recipient, please describe the authority to act on the individual's behalf (*such as Power of Attorney or Legal Guardian*). If not already on record with the agency, please provide legal documentation showing this authority.

Best Payments

JFS Authorized Representative – Follow Up Questions

Client Name _____
Date _____

The following questions will be asked during the initial JFS Interview
The application process will go quicker if we have the Answers

How much Schooling has the Applicant completed? _____

If the Applicant Graduated, what year? _____

Is the Applicant Blind and/or Deaf? _____

Does the Applicant have a DL or State ID? _____

Does the Applicant own a Car? _____

Does the Applicant have Life Insurance? _____

Does the Applicant have a Burial Plan? _____

Does the Applicant file Taxes? _____

Completed By: _____
Phone Number: _____