AllTrust
Payee Corp., Inc.

Representative Payee Services

Once we are appointed by Social Security to serve as your Representative Payee to manage your Social Security benefit, we work with you to develop a customized budget based on your income and expenses. We are glad to work with caseworkers and other persons you authorize to assist us in managing your finances.

We schedule regular bills and rents to be mailed by the third of the month after verifying we receive your deposit. We estimate utility and other fluctuating bills to be paid when the actual bill is received by our office. In order to pay your bills promptly you will need to change the billing address to our address:

Your Name
c/o AllTrust Payee Corp., Inc
P.O. Box 650369
Vero Beach, FL 32965

If you move, notify our office right away! Most rents are scheduled to be released on the 1st or the 3rd. We REQUIRE at least 5 business days to process a rent change to ensure proper procedure. If you fail to report changes in a timely manner, you run the risk of rent being paid to the landlord on record.

If you are homeless/traveling monthly verbal contact is REQUIRED. You MUST call the office to confirm the following information - Name, Date of Birth, Mailing Address, Phone/Message Number and Any Changes. ***Failure to report could result in holding your personal spending until contact is made.**

We issue re-loadable debit cards for your grocery and/or spending money. The amount and load schedule depend on your personalized budget. The debit card is ONLY uploaded on Tuesdays.

Additional funds must be faxed over NO later than Thursday at 3pm in order to be processed for the following week. We will need the receipts for any additional funds given. You can fax, email, or mail us your receipts. Additional funds are not given the first or last weeks of the month, due to rents and changes being made.

We try to build savings into your budget for Christmas, birthdays, clothing twice a year, summer entertainment and emergencies.

As a Non-Profit Organizational Payee we are authorized by Social Security to collect a fee for our service. This fee is determined by Social Security each year. The current fee is $57 per month. There is an additional banking fee of approximately $1.50 per month. *Fees are subject to change according to SSA policy.

Our phone hours are Monday through Thursday 9:00 am till 1:00 pm. We are unavailable on Friday's due to banking and accounting purposes. If we are unable to answer your call, please leave one detailed message with your telephone number and we will return your call as soon as possible.

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Client Intake Packet

Full Name:	Social Security Number:	Date of Birth:
City & State of Birth:	Mother's Maiden Name:	Father's First Name:
Home Phone:	Cell/Message Phone:	Email:
Physical Address:	Check Box if Homeless: ☐	Mailing Address: (*If Different or HOMELESS*)

Monthly Benefit Type & Amount	SSI	SSD	VA	WAGES	OTHER

Employer *(If Applies)*	Name:	Phone:

Emergency Contact	Name:	Relationship:	Phone:
Caseworker	Name:	Agency:	Phone:
Check box and include information if applies	☐ Trust:	☐ Funeral Plan:	☐ Guardianship:
Current Payee Information	Name:	Phone:	I am currently my own payee: YES/NO

Estimated Budget

Type	Amount	Date	Vender Name/Address
Rent			
Phone/Internet/Cable			
Utilities			
Payee Fee			
Other			

By completing and signing this form I give permission for AllTrust Payee Corp., Inc. to apply with Social Security to be selected as my Representative Payee and manage my Social Security Benefit(s). I understand a fee for Service will be charged.

Client Signature:	Date:

AllTrust Payee Corp., Inc.
P.O. Box 650369 Vero Beach, FL 32965
PH: (772)226-0165 Fax: (772)618-4647 Email: Admin@alltrustpayee.com
Non-Profit 501(c)3

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LANDLORD AGREEMENT

Client Name:	Telephone:

☐ Renting a Room That INCLUDES Utilities
**I am renting a room that is a fair share and current market amount. I have access to cooking facilities, but must buy my own food.*

☐ *Shared Rent: *(Please complete ROOMMATE information below)*

☐ Assisted Living/Adult Foster Home *(Please provide a copy of the 512 if available)*

☐ Renting and Paying for Utilities *(Please provide a copy of your signed lease agreement)*

☐ Other: *(Please describe)* _____

Client - New Address Information

Address:	Mailing Address: *(If Different)*

*Roommate Name(s): complete *'s if shared rent	*Date of Birth(s):	*Income:

Landlord Information

Payable To:	Contact Telephone:	Move In Date:
Mailing Address:		Rent Amount:

Name of Facility: *(Assisted Living/AFH/Other Facility)*	Contact: *(Assisted living/AFH/Other Facility)*

Landlord Signature:

By signing this form I as the landlord hereby agree to notify AllTrust Payee Corp., Inc. immediately if the tenant is relocated, hospitalized or institutionalized. This form indicates a month by month rental agreement and any rent received when the tenant is no longer living at the property will be returned to AllTrust in a timely manner.

Landlord Signature: Date:

Tenant Signature:

By signing this form, I hereby agree that all of the above is true to the best of my knowledge. I agree to notify AllTrust Payee Corp., Inc. immediately if I decide to move, become hospitalized, or institutionalized if capable.

Tenant Signature: Date:

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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.

- 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 ontime 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 $57.00 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 monthly banking fee of up to $1.50 will be charged. **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.

_____ _____

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PH: (772)226-0165 Fax: (772)618-4647 Email: Admin@alltrustpayee.com
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AllTrust
Payee Corp., Inc.

Client Signature Date

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

_____ _____

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Advance Notification of Representative Payment

Name of Wage Earner, Self-Employed Person or SSI Claimant	Social Security Number – –
Signature of Applicant or Parent/Guardian	Date
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 _____)(_____

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)
Destroy Prior Editions

Consent for Release of Information

You must complete all required fields. We will not honor your request unless all required fields are completed. *(*Signifies a required field. **These are not mandatory fields for the consent form to be acceptable. Please complete these fields in case we need to contact you about the consent form).*

TO: Social Security Administration

*Full Name	*Date of Birth (MM/DD/YYYY)	*Full Social Security Number

I authorize the Social Security Administration to release information or records about me to:

***NAME OF PERSON OR ORGANIZATION:**

ALLTRUST PAYEE CORP, INC.

***ADDRESS OF PERSON OR ORGANIZATION:**
**** PHONE NUMBER OF PERSON OR ORGANIZATION:**

PO BOX 350369
VERO BEACH, FL 32965-0369
772-226-0165

***I want this information released because:**
We may charge a fee to release information for non-program purposes.

***Please release the following information selected from the list below:**
Check at least one box. If requesting medical records, do not check both boxes 7 and 8. We will not disclose records unless you include specific date ranges where applicable.

1. ☐ Verification of Social Security Number
2. ☐ Current monthly Social Security benefit amount
3. ☐ Current monthly Supplemental Security Income payment amount
4. ☐ Social Security benefit amounts from date _____ to date _____
5. ☐ Supplemental Security Income payment amounts from date _____ to date _____
6. ☐ Medicare entitlement from date _____ to date _____
7. ☐ Medical records from date _____ to date _____
8. ☐ Complete medical records
9. ☒ Other Social Security record(s) (We will not honor a request for "any and all records" or "the entire file." You must specify which records you are seeking. For example, award/denial notices, benefit applications, appeals)

DPQY

I am the individual, to whom the requested information or record applies, or the parent or legal guardian of a minor, or the legal guardian of a legally incompetent adult. I declare under penalty of perjury (28 CFR § 1746) that I have examined all the information on this form and it is true and correct to the best of my knowledge. I understand that anyone who knowingly or willfully seeks or obtains access to records about another person under false pretenses is punishable by a fine of up to $5,000.

***Signature:** _____ ***Date:** _____

****Address:** _____ ****Daytime Phone:** _____

****Relationship (if not the subject of the record):** _____ ****Daytime Phone:** _____

Witnesses must sign this form ONLY if the above signature is by mark (X). If signed by mark (X), two witnesses to the signing who know the signee must sign below and provide their full addresses. Please print the signee's name next to the mark (X) on the signature line above.

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)