



RELEASE TO OBTAIN AND DISCLOSE INFORMATION

I/We, _____, authorize Consumer Credit Counseling Service /Compass of Carolina to obtain and disclose pertinent information from my/our records to/from:

The purpose of my/our request is:

I/We authorize the release of information:

- ___ For one time only (within 90 days). ___ For as long as Compass of Carolina serves as my Representative Payee.
- ___ For up to one year.

I understand that my records are protected under the Federal Confidentiality Regulations and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I understand that I may revoke this consent at any time, provided that action has not been taken in reliance upon this authorization. Without written notice to withdraw this consent, it expires at the earlier of the listed expiration date or upon release of the information. The nature of this consent form has been explained to me/us and I/We understand its contents.

Client Signature(s):

Date: _____

Other Signature: _____

Relationship to Client (s): _____

Signature of Witness: _____

Signature of Counselor: _____

Representative Payee Face Sheet

Name: _____ Social Security # _____
 _____ VA Claim# _____

Address _____ Date of Birth _____

City/State/Zip Code _____

Telephone # _____

How Long At Current Address? _____ Name of Last Payee _____

Why are you changing your Rep. Payee? _____

Are your basic living expenses No
 being met now? _____

Referral Source	Marital Status	Race
Friend/Family	Married	African American
Creditor	Single	Asian American
Telephone Book	Divorced	Caucasian
TV/Radio	Widowed	Hispanic/Mexican
	Living Together	

Dependents:		
How Many? _____		
Do they live with you?	Yes	or No
Age: _____		
Name	Age: _____	
Name	Age: _____	

Monthly Income	SSA

	SSI

	VA

	Other

	TOTAL

Contact Name: _____



CONSUMER CREDIT
COUNSELING SERVICE

Contract for Representative Payee Clients

I have discussed my financial needs with my counselor at Compass of Carolina. I agree to have Compass of Carolina serve as my representative payee for Veterans Benefits, Social Security and/or SSI payments.

I will:

- Be clean and sober when I come to conduct business
- Treat staff with courtesy and respect
- Come to conduct business only when I have called and arranged an appointment
- Receive \$ _____ for my spending money every _____ as agreed.

In the event of a financial emergency, I will contact Compass of Carolina and speak with my counselor about my emergency. I will provide receipts for anything that I have to purchase in the event of an emergency.

In the event that I choose to change my payee to someone else and then decide to return to Compass of Carolina I will pay a reinstatement fee of \$50.00 to Compass of Carolina. This money will be paid either up front or out of my first Veteran, Social Security and or SSI check that Compass receives.

I/WE AGREE TO THE FOLLOWING MONTHLY SERVICE CHARGE \$ _____.

Compass of Carolina will:

- Treat me with courtesy and respect
- Be available to meet with me at scheduled appointments
- Use funds received on my behalf to meet my current needs for basic living expenses
- Report to Social Security Administration any events that may affect my eligibility for payments or payment amounts
- Account to Social Security any unspent funds, if any, in a way that clearly show the funds belong to me
- Return to Social Security any funds that have been saved for me (in the event of a change in representative payee) or that were sent for my benefit but which I am not entitled.

Beneficiary Signature: _____

Date: _____

Rep. Payee Signature: _____

Date: _____

COMPASS OF CAROLINA
PRIVACY POLICY
REPRESENTATIVE PAYEE SERVICES

Our agency is committed to assuring the privacy of individuals and/or families who have contacted us for assistance. We assure you that all information shared both orally and in writing will be managed within legal and ethical considerations. Your "personal financial information", such as your total debt information, income, living expenses, and personal information concerning your financial circumstances, will be provided to creditors and possibly others with your specific authorization.

We may also use aggregated case file information for the purpose of evaluating our services, gathering valuable research information and designing future programs. Your anonymity will be maintained through the use of your client number or by using aggregate data in all circumstances.

In all other situations, your information may be released to appropriate individuals or agencies **ONLY UPON YOUR WRITTEN REQUEST or when our staff has been served by a valid subpoena.**

The following PRIVACY PRACTICES detail circumstances under which we will release your information to a third party.

1. We do not disclose any nonpublic personal information about our clients or former clients to anyone, except as permitted by law.
2. We may compile data and aggregate information that you give to us, but this information may not be disclosed in a manner that would personally identify you in any way.
3. We may disclose some or all of the information that we collect, as described below, to creditors, or third parties that you have authorized who need this information in order for us to assist you after a counseling session.
4. We may disclose all of the information that we collect, as described below, to creditors and related financial institutions who need this information in order to put you on a debt management plan (DMP).
5. We restrict access to nonpublic personal information about you to those employees who need to know that information to provide services to you. We maintain physical, electronic and procedural safeguards that comply with federal regulations to guard your nonpublic personal information.
6. We collect nonpublic personal information about you from the following sources:
 - Information we received from you on our applications or other forms you provide;
 - Information about your transactions with us, your creditors, or others; and
 - Information we receive from a credit reporting agency.
7. We may disclose the following kinds of nonpublic information about you:
 - Information we received from you on applications or other forms, such as your name, address, social security number, assets, and income;
 - Information about your transactions with us, your creditors, or others, such as your account balance, payment history, parties to transactions and credit card usage; and
 - Information we receive from a credit reporting agency, such as your credit history.

RELEASE: I hereby release Compass of Carolina to release all non-public information it obtains about me to (1) my creditors and (2) any third parties necessary to resolve the matter(s) discussed during my counseling session.

I further RELEASE and authorize all of my creditors to provide non-public information about me to Compass of Carolina.

Client signature

Client signature

Date

Please print client name

Please print client name

COMPASS OF CAROLINA
COUNSELING AGREEMENT AND UNDERSTANDING
FOR REPRESENTATIVE PAYEE SERVICES

IMPORTANT CLIENT INFORMATION

1. I understand the agency will provide a confidential and comprehensive personal money management interview and this interview will be conducted by a certified consumer credit counselor or qualified professional credit counselor. CCCS is a professional non-profit financial counseling service.
2. I understand that in the event I am dissatisfied, I may utilize the Complaint Resolution Process.
3. I hold the agency, its employees, agents, and volunteers harmless from any claim, suit, action or demand of my creditors, myself or any other person resulting from advice or counseling.
4. I may qualify and choose to enroll into the agency's Debt Management Plan (DMP). Under the DMP the agency serves as a neutral 3rd party in negotiating with creditors to liquidate my financial obligations.
5. If I participate in a Debt Management Plan the agency may obtain a copy of my credit report and may inform any credit reporting agency (CRA) of my participation. CCCS and Compass of Carolina have no control, responsibility, or obligation for past, present, or future credit ratings that I may receive from my creditors. In certain circumstances a Debt Management Plan may affect my credit rating negatively.
6. If I enroll into a Debt Management Plan I will be given complete details of the operation, requirements, and responsibilities of the plan.
7. A counselor may give generic and broad answers to questions about bankruptcy, **but will not give legal advice**. I will obtain legal advice from an attorney and understand CCCS is not a substitute for legal counsel. I may obtain legal counsel from any attorney I choose. CCCS will not make specific referrals to any legal firm or attorney for such advice.
8. At some time in the future a neutral third party may contact me to request an evaluation of the services I have received.
9. I may be referred to other services offered by Compass or to other services and organizations that are available in our community that may assist me in solving particular problems that have been identified. CCCS makes no guarantees or assurances with regards to actual services you receive from referrals to outside agencies.
10. In compliance with the USA PATRIOT Act, my signature below is verification that I am not a terrorist, nor will any information gained from the counseling received be used to support terrorist activity.

BILL OF RIGHTS CCCS and Compass of Carolina pledge our clients have the following rights:

- To prompt counseling services and prompt response to our clients' questions and concerns;
- To treatment with dignity and respect;
- To be actively involved in comprehensive financial assessment and making appropriate client action plans;
- To express dissatisfaction through the use of a formal Complaint Resolution Process;
- To voluntarily discontinue the relationship with our agency at any time.

COMPLAINT RESOLUTION PROCESS

We are committed to providing you with high quality professional services. However, if you are not satisfied with the services provided or would like make a complaint, we ask that you please follow these guidelines.

- Step 1. Try to resolve the issue with the staff member involved. Please be specific about your complaint.
- Step 2. If #1 is not possible or the issue is still unresolved, contact the CCCS Program Director at 467-3434 or 1-800-203-9692.
- Step 3. A member of agency management may contact you by phone or request a face-to-face meeting to gather more information and may also meet with any and all staff members involved. The agency manager will then respond to you within 15 days.
- Step 4. If your issue is still unresolved you may appeal in writing directly to the head of the agency (Mr. Thomas Bannister, President, Compass of Carolina). After additional fact-finding and research, the agency head will provide a concluding decision to you within 15 days.

NON-DISCRIMINATION POLICY

Our agency serves all members of the community. We do not participate in the practices of discrimination in the selection and participation of clients in our programs or services with respect to race, religion, color, gender, national origin, or handicap.

RELEASE AND AUTHORIZATION TO OBTAIN CREDIT REPORT

In order to enable Compass of Carolina to assess my financial situation, and in connection with the financial counseling I receive, I (we) authorize Compass of Carolina to obtain my (our) credit report. I understand that said credit report will be the sole property of the agency and I will not receive a copy of my credit report. All information contained in my credit report will be considered confidential and used for legitimate business purposes under the Fair Credit Reporting Act.

Client signature

Client signature

Date

Counselor signature

Advance Notification of Representative Payment

Name of Wage Earner, Self-Employed Person of SSI Claimant

Social Security Number

Name of Beneficiary (if other than above)

Relationship to Wage Earner, Self-Employed Person of 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 interest.

Choice of Representative Payee

SSA has selected Compass of Carolina to be my representative payee.

My Right to Appeal

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 also have the right to appeal the decision that I need a payee. If I appeal, I will have the right to review the evidence in the file and submit new evidence.

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 & Street, City, State, and Zip Code)	Address(Number & Street,City,State, and Zip Code)

PHYSICIAN'S/MEDICAL OFFICER'S STATEMENT OF PATIENT'S CAPABILITY TO MANAGE BENEFITS

Paperwork Reduction Act Statement - This information collection meets the requirements of 44 U.S.C. § 3507, as amended by Section 2 of the Paperwork Reduction Act of 1995. You do not need to answer these questions unless we display a valid Office of Management and Budget control number. We estimate that it will take about 10 minutes to read the instructions, gather the facts, and answer the questions. **SEND THE COMPLETED FORM TO YOUR LOCAL SOCIAL SECURITY OFFICE.** To find the nearest office, call 1-800-772-1213. Send only comments on our time estimate above to: SSA, 6401 Security Boulevard, Baltimore, MD 21235-6401.

In replying, use this address:
SOCIAL SECURITY ADMINISTRATION

TELEPHONE NUMBER (Including Area Code)

() -

DATE

SSA CONTACT

Privacy Act: This report is authorized by sections 205(a) and 205(j) of the Social Security Act, as amended (42 U.S.C. 405(a) and 405(j)). While you are not required to respond, your cooperation will help us decide whether any Social Security benefits that may be due should be paid directly to the patient or to someone else on the patient's behalf. Your cooperation in completing and returning this statement will be appreciated.

IDENTIFYING INFORMATION (SSA Only)
If different from patient

We may also use the information you give us when we match records by computer. Matching programs compare our records with those of other Federal, State, or local government agencies. Many agencies may use matching programs to find or prove that a person qualifies for benefits paid by the Federal government. The law allows us to do this even if you do not agree to it. Explanations about these and other reasons why information you provide may be used or given out are available in Social Security Offices. If you want to learn more about this, contact any Social Security Office.

NAME OF WAGE EARNER OR SELF-EMPLOYED PERSON

SOCIAL SECURITY NUMBER

PATIENT'S NAME

PATIENT'S ADDRESS (Number and Street, City, State, and ZIP Code)

PATIENT'S SOCIAL SECURITY NUMBER

PATIENT'S DATE OF BIRTH

YOUR HELP IS NEEDED

The patient shown above has filed for or is receiving Social Security or Supplemental Security Income payments. We need you to complete the back of this form and return it to us in the enclosed envelope to help us decide if we should pay this person directly or if he or she needs a representative payee to handle the funds. **Please Note:** This determination affects how benefits are paid and has no bearing on disability determinations; **SSA will NOT pay for this information.** Thank you for your help.

WHO IS A REPRESENTATIVE PAYEE

A representative payee is someone who manages the patient's money to make sure the patient's needs are met. The payee has a strong and continuing interest in the patient's well-being and is usually a family member or close friend.

WHO NEEDS A REPRESENTATIVE PAYEE

Some individuals age 18 and older who have mental or physical impairments are not capable of handling their funds or directing others how to handle them to meet their basic needs, so we select a representative payee to receive their payments. Examples of impairments which may cause incapability are senility, severe brain damage or chronic schizophrenia. However, even though a person may need some assistance with such things as bill paying, etc., does not necessarily mean he/she cannot make decisions concerning basic needs and is incapable of managing his/her own money.

PLEASE COMPLETE THE INFORMATION ON THE REVERSE OF THIS FORM

