Representative Payee Application

Compass OF CAROLINA

Demographics

Today's Date: _____

Personal Information (Please Be Sure to Fill In All Information)	**Required SSA Information**
Full Name	**Mother's Maiden Name**
	How Long At This Address?
Social Security Number	**City Of Birth**
VA CLAIM #	
DOB	
	Criminal Record?

Living Arrangements

Current Mailing Address:	**Current Number Of People In The Home**_____
Street/PO Box	
City	
Zip Code	
Phone/Contact	
Best Contact #_____	
Email Address_____	
Is mailing address the same as physical? If Not List Below	
Physical Address	
County Of Residence	

Name	**Relation**	**Age**

Race	**Gender**	**Maritial Status**

Payee Misc Information

Name Of Prior Payee or List Self	**What has caused you to need a Rep Payee/Fiduciary?**
_____	
Reason For Change of Payee	**Referral Source**
_____	**Case Manager?** / **If Yes Please List Name and Phone#**

Notes

Return this form Mail to: 1100 Rutherford Road Greenville, SC 29609 Fax to: 864-467-3571

Representative Payee Asset Form

Asset List	
Today's Date:	
Stocks	Company/Value
Bonds	Total Amount?
Royalties	Type
Savings Account#	Bank Name
Checking Account#	Bank Name
Property Other than Residence	Tax Map#
Funeral Plan	Cash Value
Income/Benefits Received	
Employment	Employer Name
Hourly Wage	Average Hours Per Week
Food Stamps	
Medicaid	
Section 8 Or Rent Assistance	
VA benefits	
Retirement/Pension	
Notes	
Signature/Acknowledgements	
I affirm that all information provided is true and up to date. I also understand that it is my resposibility to update my records in writing in a timely fashion.	
Client Signature	Date
I aknowledge and give permission for Compass of Carolina to discuss my case with the following: Case managers, Department of Human Services, Law Enforcement, and any other vendor or agency that may be deemed necessary to ensure proper maintenance of my finances.	
Client Signature	Date
Rep Payee Counselor Signature	Date
Date Of First Appointment :	

Monthly Budget For : _____

Monthly Income	Amount	Due
Salary /Earnings		
SSA		
SSI		
VA/Retirement		
Total		

Charity and Giving	Amount	Due
Tithes		
Offerings		
Charities		
Total		

House Expenses	Amount	Due
Mortgage/Rent		
Taxes		
Insurance		
Fees/ Maintenance		
Other		
Total		

Utilities	Amount	Due
Power		
Water		
Gas/Fuel		
Cable		
Internet		
Phone (Home &Cell)		
Total		

Transportation Costs	Amount	Due
Car Payment		
Insurance		
Fuel		
Repairs		
Bus Fare		
Taxi/Cab		
Other		
Total		

Health/Living	Amount	Due
Groceries		
Household Supplies		
Hair Care		
Health Insurance		
Clothing		
Entertainment		
Pet Care		
Medications		
Total		

Debts	Amount	Due
Legal Fees		
Fines		
Total		

Monthly Budget Totals	
Total Income	
Total Expenses	
Total Monthly Remaining	

Representative Payee Privacy Policy

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, creditors, 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 fil information for the purpose of evaluating our services, gathering valuable research information and designing future programs. In all other situation, your information may be released to appropriate individuals and agencies only upon your written request of 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 us, but this information may 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 and who need this information in order to assist you after a counseling session or as a part of the services we have agreed to provide you.
4. 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 you nonpublic personal information.
5. We collect nonpublic personal information about you from the following sources:
    a. Information we received from you on you applications and other forms you completed.
    b. Information about your transactions with us, your creditors, or others.
6. We may disclose the following kinds of nonpublic information about you:
    a. Information we received from you on application or other forms, such as your name, address, social security number, assets, and income.
    b. Information about your transactions with us, your creditors, or others, such as your account balance, payment history, parties to transactions and credit card usage.

Release: I hereby release Compass of Carolina to release all nonpublic information it obtains about me to (1) my creditors and (2) any third parties necessary to resolve he matters discussed during my counseling session or to provide the services we have agreed to provide for you.

I further release and authorize all of my creditors to provide nonpublic information about me to Compass of Carolina.

Client Signature Date

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Representative Payee
Release to Obtain and Disclose Information

Printed Client Name

Date Revoked:_____

Client Signature

Personal:

I authorize Compass of Carolina to obtain and disclose pertinent information from my records to/from:

Name	Phone #	Relationship
Name	Phone #	Relationship
Name	Phone	Relationship

Emergency Contact:

I authorize Compass of Carolina to contact the following individuals with any emergency situations that may arise:

Name	Phone #	Relationship
Name	Phone #	Relationship

Medical Groups, Social Agencies, & Financial Institutions:

I authorize Compass of Carolina to obtain and disclose pertinent information about my record to/from any relevant medical group, social agency, or financial institution.

I authorize the release of information for/through:

- ○ As long as Compass of Carolina serves as my Representative Payee
- ○ 90 days
- ○ The specific date of _____

I understand that my records are protected under 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. The nature of this consent form has been explained to me and I understand its contents. I agree with all terms stated above by provided my signature or mark below.

Client Signature Date

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Representative Payee Client Contract

I have discussed my financial needs with my counselor and I agree to have Compass of Carolina serve as my Representative Payee for my VA Benefits/Social Security Benefits/Supplemental Security Income Benefits.

I, _____ agree to the following statements:

- I will be clean and sober when I come in to conduct business
- I will treat staff with courtesy and respect
- I will come to conduct business at Compass of Carolina only when I have called and made an appointment
- I will follow my budget that has been discussed with my counselor
- I will provide receipts for **ALL** funds disbursed by Compass of Carolina
- I will not repetitively call Compass of Carolina or leave multiple messages when I have questions
- I will advise my Representative Payee Counselor of any changes that may affect my eligibility for benefits

In the event of a financial emergency, I will contact Compass of Carolina and speak with my Counselor.

I agree to direct my bills to Compass of Carolina and I understand that my Representative Payee will pay them as my funds allow. I understand that Compass of Carolina is not liable for any of my bills that are not paid due to a lack of funds in my account. I also agree to present my bills to Compass of Carolina in a timely manner and understand that if I don't, there may be a delay in paying them.

I agree to pay the monthly service charge established by the Social Security Administration/Veterans Administration. Currently the fee is $ _____ a month.

The Representative Payee Department at Compass of Carolina agrees to the following statements:

- We will treat you with courtesy and respect
- We will be available to meet with you at your scheduled appointments
- We will use your benefits received on your behalf to meet your needs and basic living necessitates
- We will report to the correct government agency any events that may affect your eligibility for benefits
- We will account to the correct government agency for any unspent funds in a way that clearly shows those funds belong to you
- We will return to the correct government agency any funds that have been saved for you when you are no longer a Compass of Carolina client
- We will return to the correct government agency any funds that you are not entitled to that we have received on your behalf

Client Signature Date

Counselor Signature Date

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Representative Payee
Need for Organizational Payee

Verification of Need for an Organizational Representative Payee:

Client Name: _____ SSN: _____

I, _____ verify that I am seeking assistance from Compass of Carolina due to the lack of eligible family members or friends that are able to act as Representative Payee on my behalf.

Notes from current payee no longer willing to serve (if applicable):

_____

_____

_____

_____

Intake Situation Notes:

_____

_____

_____

_____

Client Signature Date

Counselor Signature Date

SOCIAL SECURITY ADMINISTRATION **TOE 250**

Form Approved
OMB No. 0960-0014

REQUEST TO BE SELECTED AS PAYEE

PRINT IN INK:

FOR SSA USE ONLY							
Name or Bene. Sym.	Program	Date of Birth	Type	Gdn.	Cus.	Inst.	Nam.

FOR SSA USE ONLY

DISTRICT OFFICE CODE

STATE AND COUNTY CODE:

The name of the NUMBER HOLDER

SOCIAL SECURITY NUMBER

The name of the PERSON(S) (if different from above) for whom you are filing (the "claimant(s)")

SOCIAL SECURITY NUMBER(S)

Answer item 1 ONLY if you are the claimant and want your benefits paid directly to you.

1. I request that I be paid directly.

   CHECK HERE ☐ and answer only items 3, 5, 6, and 8 before signing the form on page 4.

I REQUEST THAT THE SOCIAL SECURITY, SUPPLEMENTAL SECURITY INCOME, BLACK LUNG OR SPECIAL VETERANS BENEFITS FOR THE CLAIMANT(S) NAMED ABOVE BE PAID TO ME AS REPRESENTATIVE PAYEE.

2. Explain why you think the claimant is not able to handle his/her own benefits.
   (In your answer, describe how he/she manages any money he/she receives now.)

   ☐ Claimant is a minor child.

3. Explain why you would be the best representative payee. (Use Remarks if you need more space.)

   Our agency would use the benefits received to meet our clients needs.

4. If you are appointed payee, how will you know about the claimant's needs?

   ☐ Live with me or in the institution I represent.
   ☐ Daily visits.
   ☐ Visits at least once a week.
   ☒ By other means. Explain:

   Schduled appointments, telephone, and postal mail.

5. Does the claimant have a court-appointed legal guardian? ☐ YES ☐ NO

   IF YES, enter the legal guardian's:

   NAME _____

   ADDRESS _____

   PHONE NUMBER _____

   TITLE _____

   DATE OF APPOINTMENT _____

Explain the circumstances of the appointment. (Use remarks if you need more space.)

6. (a) Where does the claimant live?

- ☐ Alone
- ☐ In my home (Go to (b).)
- ☐ With a relative (Go to (b).)
- ☐ With someone else (Go to (b).)
- ☐ In a board and care facility (Go to (b).)
- ☐ In a public institution (Go to (c).)
- ☐ In a private institution (Go to (c).)
- ☐ In a nursing home (Go to (c).)
- ☐ In the institution I represent (Go to (c).)

(b) Enter the names and relationships of any other people who live with the claimant.

NAME	RELATIONSHIP

(c) **Enter the claimant's residence and mailing addresses (if different from yours).**

Residence: **Mailing:** **Telephone Number:**

(d) Do you expect the claimant's living arrangements to change in the next year?

☐ YES ☒ NO If YES, explain what changes are expected and when they will occur. (Use Remarks if you need more space.)

7. If you are applying on behalf of minor child(ren) and you are not the parent,

Does the child(ren) have a living natural or adoptive parent? ☐ YES ☒ NO

If YES, enter: (a) Name of parent _____

(b) Address of parent _____

(c) Telephone number _____

(d) Does the parent show interest in the child? ☐ YES ☐ NO

Please explain. _____

8. List the names and relationship of any (other) relatives or close friends who have provided support and/or show active interest with the claimant. Describe the type and amount of support and/or how interest is displayed.

NAME	ADDRESS/PHONE NO.	RELATIONSHIP	DESCRIBE SUPPORT/INTEREST

9. Check the block that describes your relationship to the claimant.

(a) ☒ Official of bank, agency or institution with responsibility for the person. Enter below which you represent:

- ☐ Bank
- ☒ Social Agency
- ☐ Public Official
- ☐ Institution:
  - ☐ Federal
  - ☐ State/Local
  - ☐ Private non-profit
  - ☐ Private proprietary institution. Is the institution licensed under State law? ☐ YES ☐ NO

IF (a) ABOVE CHECKED, COMPLETE ONLY QUESTIONS 10 AND 11 AND SIGN THE FORM ON PAGE 4.

(b) ☐ Parent

(c) ☐ Spouse

(d) ☐ Other Relative - Specify _____

(e) ☐ Legal Representative

(f) ☐ Board and Care Home Operator

(g) ☐ Other Individual - Specify _____

IF (b), (c), (d), or (e) ABOVE CHECKED, GO ON TO QUESTION 12

INFORMATION ABOUT INSTITUTIONS, AGENCIES AND BANKS APPLYING TO BE REPRESENTATIVE PAYEE

10. (a) Enter the name of the institution Compass of Carolina

(b) Enter the EIN of the institution 57-0381870

11. Is the claimant indebted to your institution for past care and maintenance? ☐ YES ☒ NO
If YES, give the amount of the debt, the date(s) the debt was incurred and the description of the debt.

INFORMATION ABOUT INDIVIDUALS APPLYING TO BE REPRESENTATIVE PAYEE

12. Enter: YOUR NAME NA

DATE OF BIRTH NA

SOCIAL SECURITY NUMBER NA

ANY OTHER NAME YOU HAVE USED NA

OTHER SSN'S YOU HAVE USED NA

13. How long have you known the claimant? NA

14. Does the claimant owe you any money now or will he/she owe you money in the future? ☐ YES ☒ NO
If YES, enter the amount he/she owes you, the date(s) the debt was/will be incurred and describe why the debt was/will be incurred.

15. If the claimant lives with you, who takes care of the claimant when work or other activity takes you away from home? What is his/her relationship to the claimant?

16. (a) Main source of your income

- ☐ Employed (answer (b) below)
- ☐ Self-employed (Type of Business _____)
- ☐ Social Security or Black Lung benefits (Claim Number _____)
- ☐ Pension (describe _____)
- ☐ Supplemental Security Income payments (Claim Number _____)
- ☐ AFDC (County & State _____)
- ☐ Other Welfare (describe _____)
- ☐ Other (describe _____)

(b) Enter your employer's name and address:

How long have you been employed by this employer? _____

(If less than 1 year, enter name and address of previous employer in Remarks.)

17. (a) Have you ever been convicted of a felony? ☐ YES ☒ NO

If YES: What was the crime? _____

On what date were you convicted? _____

What was your sentence? _____

If imprisoned, when were you released? _____

If probation was ordered, when did/will your probation end? _____

(b) Have you ever been convicted of any offense under federal or state law which resulted in imprisonment for more than one year? ☐ YES ☒ NO

If YES: What was the crime? _____

On what date were you convicted? _____

What was your sentence? _____

If imprisoned, when were you released? _____

If probation was ordered, when did/will your probation end? _____

18.	Do you have any unsatisfied FELONY warrants (or in jurisdictions that do not define crimes as felonies, a crime punishable by death or imprisonment exceeding 1 year) for your arrest? ☐ YES ☒ NO If YES: Date of Warrant_____ State where warrant was issued_____
19.	How long have you lived at your current address? (Give Date MM/YY) (If less than 1 year, enter previous address in Remarks)

REMARKS: *(This space may be used for explaining any answers to the questions. If you need more space, attach a separate sheet.)*

As an authorized organization, we will will collect a fee for acting at this person's representative payee. We are not a creditor of this individual.

PLEASE READ THE FOLLOWING INFORMATION CAREFULLY BEFORE SIGNING THIS FORM

I/my organization:

- Must use all payments made to me/my organization as the representative payee for the claimant's current needs or (if not currently needed) save them for his/her future needs.
- May be held liable for repayment if I/my organization misuse the payments or if I/my organization am/is at fault for any overpayment of benefits.
- May be punished under Federal law by fine, imprisonment or both if I/my organization am/is found guilty of misuse of Social Security or SSI benefits.

I/my organization will:

- Use the payments for the claimant's current needs and save any currently unneeded benefits for future use.
- File an accounting report on how the payments were used, and make all supporting records available for review if requested by the Social Security Administration.
- Reimburse the amount of any loss suffered by any claimant due to misuse of Social Security or SSI funds by me/my organization.
- Notify the Social Security Administration when the claimant dies, leaves my/my organization's custody or otherwise changes his/her living arrangements or he/she is no longer my/my organization's responsibility.
- Comply with the conditions for reporting certain events (listed on the attached sheets(s) which I/my organization will keep for my/my organization's records) and for returning checks the claimant is not due.
- File an annual report of earnings if required.
- Notify the Social Security Administration as soon as I/my organization can no longer act as representative payee or the claimant no longer needs a payee.

I declare under penalty of perjury that I have examined all the information on this form, and on any accompanying statements or forms, and it is true and correct to the best of my knowledge.

SIGNATURE OF APPLICANT	DATE *(Month, day, year)*
Signature *(First name, middle initial, last name) (Write in ink)* **SIGN HERE** ▶	Telephone number(s) at Which You May Be Contacted During the Day 864-467-3434

Print Your Name & Title *(if a representative or employee of an institution/organization)*

Mailing Address *(Number and street, Apt. No., P.O. Box, or Rural Route)*
1100 Rutherford Road

City and State	Zip Code	Name of County
Greenville, SC	29609	Greenville

Residence Address *(Number and street, Apt. No., P.O. Box, or Rural Route)*

City and State	Zip Code	Name of County

Witnesses are only required if this application has been signed by mark (X) above. If signed by mark (X), two witnesses to the signing who know the applicant making the request 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)*