GREATER TRIANGLE REPRESENTATIVE PAYEE SERVICES, INC.

Representative Payee Application

I hereby authorize Greater Triangle Representative Payee Services, Inc. to manage by benefits and to serve as my organizational representative payee. I understand that the Social Security Administration (SSA) will send my benefits directly to my organizational representative payee. It is the responsibility of my representative payee to manage my benefits in my best interest with my prior knowledge and input, unless I am a minor child, parent or guardian of the client.

I hereby acknowledge that this consent is truly voluntary and it has been explained to me that Greater Triangle Representative Payee Service, Inc. is working as fee for service business and will collect a fee (set by the Social Security Administration) each month that I receive a benefit check.

(Fax Applications to: Greater Triangle Representative Payee Services, Inc. at 919-651-0194)

Or email forms to greatertrianglereppayee@aol.com

Client Information:

Name:____

Address:____

City:____________________State:________________________ **Zip Code**:_______________

Date of Birth:__________State of Birth__________Social Security #:________________________

Daytime Phone #_________________________Evening Phone #_______________________

Marital Status: ☐ Married ☐ Single ☐ Divorced

Employment: ☐ Employed ☐ Unemployed ☐ Retired

Current Payee & Phone #:____

Mother Maiden Name:____________________ Father's Name:__________________

GREATER TRIANGLE REPRESENTATIVE PAYEE SERVICES, INC.

Emergency Contact:

____

(Name, Phone # & Relationship):

Case Manager:

____

(Name, Phone# & Agency)

MONTHLY INCOME:

☐**SSI** ☐**SSDI** ☐**VA Benefits** ☐**Other/Specify______________**

TOTAL MONTHLY INCOME: $_________________________

Diganosis:1.____________________________2. _________________________3.___________________________

4. ___________________________ 5._________________________6.___________________________

Living Arrangements: ☐Lives Alone ☐Lives with relative, ☐Lives in family care home/Assisted Living

☐Lives in group home ☐Lives in shelter ☐Lives in public institution

GREATER TRIANGLE REPRESENTATIVE PAYEE SERVICES, INC.

____

CLIENT MONTHLY BILLS WORKSHEET

(Please indicate below whether bills are for Rent, Electricity, Home, or Cell Phone, Cable/Satellite etc.)

1.________________________ Amount: $____________________

Payment: ☐WEEKLY ☐BI-WEEKLY ☐MONTHLY ☐QUARTERLY☐ANNUALLY

Payable to:____

ADDRESS:____

2.____________________________ AMOUNT: $____________________

Payment: ☐WEEKLY ☐BI-WEEKLY ☐MONTHLY ☐QUARTERLY☐ANNUALLY

Payable to:____

ADDRESS:____

3. ________________________ AMOUNT:$____________________

Payment: ☐WEEKLY ☐BI-WEEKLY ☐MONTHLY ☐QUARTERLY☐ANNUALLY

Payable to:____

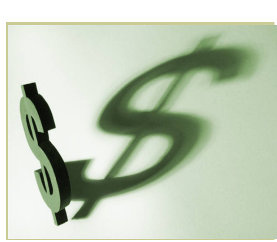
ADDRESS:____

4.___________________________ AMOUNT: $ ___________________

Payment: ☐WEEKLY ☐BI-WEEKLY ☐MONTHLY ☐QUARTERLY☐ANNUALLY

Payable to:____

ADDRESS:____



GREATER TRIANGLE REPRESENTATIVE PAYEE SERVICES, INC.

CLIENT MONTHLY BILLS WORKSHEET (cont.)

5.____________________________________ AMOUNT: $_____________________________

Payment: ☐WEEKLY ☐BI-WEEKLY ☐MONTHLY ☐QUARTERLY☐ANNUALLY

Payable to:____

ADDRESS:____

6. ____________________________________ AMOUNT: $_____________________________

Payment: ☐WEEKLY ☐BI-WEEKLY ☐MONTHLY ☐QUARTERLY☐ANNUALLY

Payable to:____

ADDRESS:____

7. ____________________________________ AMOUNT: $_____________________________

Payment: ☐WEEKLY ☐BI-WEEKLY ☐MONTHLY ☐QUARTERLY☐ANNUALLY

Payable to:____

ADDRESS:____

8. _________________________________ AMOUNT: $_____________________________

Payment: ☐WEEKLY ☐BI-WEEKLY ☐MONTHLY ☐QUARTERLY☐ANNUALLY

Payable to:____

ADDRESS:____

Please use additional sheets if needed

GREATER TRIANGLE REPRESENTATIVE PAYEE SERVICES, INC.

GTRPS00-05

AUTHORIZATION FOR REPRESENTATIVE PAYEE SERVICES

Social Security Administration has determined that assistance is needed in managing my benefits. This means that my benefits will be sent to representative payee to provide assistance that will be responsible for managing my benefits in my best interest under the guidelines of Social Security Administration.

I ________________________________(☐Client ☐Guardian ☐Legal Representative) hereby authorize Greater Triangle Representative Payee Services authorization to file an application to serve as my representative payee. I understand that this means that Greater Triangle Representative Payee Services will receive my monthly (SSA or SSI) benefit from Social Security Administration.

I understand that I have the right to appeal any decision regarding selection of representative payee with the Social Security Administration.

I understand that it's my responsibility to contact the Social Security Administration directly at any social security office to appeal my decision. I must submit my appeal within 60 days. If I decide to appeal my decision, I must submit written request to review information in my file.

_________________________________ ____

Client/Parent/Guardian/Representative Signature Date

GREATER TRIANGLE REPRESENTATIVE PAYEE SERVICES, INC.

GTRPS00-06

RELEASE OF INFORMATION

Client Name:________________________ Social Security Number:____________________

I authorize Greater Triangle Representative Payee Services to request and or disclose my financial information to:

Individual/Organization:____

Address:____

City/State:____

Zip:______________________

I understand that authorizing the request/disclose of information in my records in voluntary, and that my services will not be affect if I choose not sign this form.

I understand that any release/disclosure of information carries with it the potential for unauthorized re-disclosure and the information may not be protected by federal confidentiality laws. Authorize re-disclosure may be allowed by law.

This authorization except for action already taken can be revoked at any time by submitting a written request notice to Greater Triangle Representative Payee Services, Inc.

________________________________ ____

Client Signature / Date

Parent/Guardian/Representative Signature / Date

________________________________ ____

Witness Signature/ Date

Witness Signature / Date

GREATER TRIANGLE REPRESENTATIVE PAYEE SERVICES, INC.

GTRPS00-07

PROGRAM REQUIREMENTS

In order for Greater Triangle Representative Payee Services Inc. to provide representative payee services, I agree to following terms, and will provide the following information:

☐ A signed release form that will allow Greater Triangle Representative Payee Services, to receive my monthly bills to assure my basic needs are met.

☐ I will provide a copy of my current housing lease agreement (apartment, group home, family care, assisted living, etc.)

☐ I will provide a copy of my current guardianship ward/or legal representative information signed by the court/ with seal.

☐ A copy of FL-2 /or other documents specifying a client's current diagnosis.

☐ Any changes in housing, marital status, guardianship/legal representative and my monthly expenditures, Greater Triangle Representative Payee Services, Inc. must be notified within 30 days of change status.

☐ I will keep all scheduled appointments with Greater Triangle Representative Payee Services, Inc. regarding updates on payee account (client, parent, guardian, or representative).

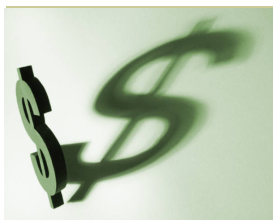
☐ I understand that in order for Greater Triangle Representative Payee Services, Inc. to provide payee services, Social Security Administration allows a representative payee to collect a fee for providing payee services. The fees are only set by Social Security Administration.

$40.00 or
$77.00 from beneficiaries entitled to disability benefits that have a drug addiction and/or alcoholism condition.

☐ I understand that if Greater Triangle Representative Payee Services, Inc. is no longer acting as my representative payee, or the client has expired, any funds remaining in the client's account will be returned to Social Security Administration.

__________________________________ ____

Client/Parent/Guardian/Representative Signature | Date



GREATER TRIANGLE REPRESENTATIVE PAYEE SERVICES, INC.

GTRPS00-08

CONSENT FOR INFORMATION

Client Name:____________________DOB:___________Social Security#:______________________

I authorize ____ to exchange specified protected information on the above name client.

Address:____

City:______________________State:______________________ Zip Code:______________

This information may include (Check all that apply)

☐ Psychiatric Evaluation ☐ Service Plans

☐ Psychological Evaluation ☐ Medication History

☐ Medication Evaluation ☐ HIV, AIDS or AIDS related information

☐ Progress Notes ☐ Financial Information

☐ Verbal Exchange of Information ☐ FL-2/MR-2

☐ Substance Abuse Evaluation (evaluations, reports)

I understand that this information will be used for:

☐ Budget Planning ☐ Treatment Planning ☐ Billing/Payment/Collections

_____________________________________ ____

Client Signature / Date Parent/Guardian/Representative Signature / Date

If representative, Please explain authority or provide documentation to act on behalf of the beneficiary/client.

Please Print Name:____

Form: GTRPS00-01