D & L REPRESENTATIVE PAYEE SERVICES

P.O. BOX 1637, WALNUT, CA 91788-1637

– A 501(c)(3) Non-Profit –

REPRESENTATIVE PAYEE SERVICES APPLICATION

Client Information:

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Move In Date: _____

Daytime Phone #: _____ Evening Phone #: _____

Date of Birth: _____ Social Security #: _____

Marital Status: ☐ Married ☐ Single ☐ Divorced

Employment: ☐ Employed ☐ Unemployed ☐ Retired

Current Payee & Phone #: _____

Mother's Maiden & Father's Names: _____

Client's Place of Birth (City & State): _____

Emergency Contact: (Name, Phone # & Relationship to you):

_____

Case Manager: (Name & Phone #): _____

Monthly Income

SSI: _____

SSA: _____

Other: _____ Name/Claim #: _____

TOTAL INCOME: _____

Additional Information:

_____

_____

_____

_____

Signature: _____ Date: _____

Client Monthly Bills Worksheet

	Amount	Who is Paid/Address	Phone #, Account # & Description
Rent/Landlord: Due Date-> _____			
Utility - Electric: Due Date-> _____			
Utilitiy - Gas: Due Date-> _____			
Phone: Due Date-> _____			
Cable/Satellite: Due Date-> _____			
Food: Due Date-> _____			

Other:

Due Date->

Amount | Who is Paid/Address | Phone #, Account # & Description

Other:

Due Date->

Other:

Due Date->

Other:

Due Date->

Total Expenses:

Additional Information:

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Voluntary Consent/Authorization & Requestfor Change of Payee Application

Client Name:_____ Social Security #: _____

AUTHORIZATION

I, _____, hereby give **D & L Representative Payee Services (DLRPS)** my authorization to file an application to be my payee. I understand this means that she will receive any SSI and/or SSA funds that I am eligible for. I understand that she will administer my benefits for me. I was referred to **DLRPS** by _____, who is my _____.

MY NEED FOR A PAYEE AND MY SELECTION FOR MY PAYEE

The Social Security Administration has determined that I need assistance in managing my benefits. This means that my benefits will be sent to a representative payee who is responsible for managing my benefits in my best interest. I choose to have **DLRPS** serve as my representative payee.

MY RIGHTS

1. I UNDERSTAND THAT I HAVE THE RIGHT TO APPEAL SOCIAL SECURITY'S DECISION AS TO WHO WILL BE MY REPRESENTATIVE PAYEE. I WILL CONTACT A SOCIAL SECURITY OFFICE IF I WANT TO APPEAL.
2. I UNDERSTAND THAT I HAVE THE RIGHT TO APPEAL THE DETERMINATION OF SOCIAL SECURITY THAT I NEED A PAYEE. IF I CHOOSE TO APPEAL, I UNDERSTAND THAT I HAVE THE RIGHT TO REVIEW THE INFORMATION IN MY FILE AND THAT I CAN SUBMIT NEW EVIDENCE FOR CONSIDERATION AND THAT I MUST FILE MY APPEAL WITHIN 60 DAYS.
3. I UNDERSTAND THAT IF I DO NOT FILE MY APPEAL WITHIN 60 DAYS THAT I MUST HAVE A GOOD REASON FOR BEING LATE. I UNDERSTAND THAT I MUST ASK FOR THE APPEAL IN WRITING AND I WILL CONTACT A SOCIAL SECURITY OFFICE IF I WANT TO APPEAL.

CONSENT TO DLRPS' PROGRAM REQUIREMENTS

A. I am aware that this is a voluntary program. If I currently live in a board and care I agree to reside in a board and care home for at least three months and to remain on the Representative Payee Program for at least six months.

B. I am informed that I cannot move out of any living facility without giving 30 days' notice to the facility, my DLRPS contact and my Mental Health Care Coordinator. I recognize that I am responsible for 30 days of payment. At the end of 30 days, I may move without penalty to another suitable living facility.

C. I understand that as part of this program, I will work with my DLRPS Representative Payee contact to determine how my money will be spent.

D. I agree to accept Mental Health Services.

E. I agree to keep all appointments with my Mental Health Care Coordinator and/or other appointments as my DLRPS contact or Mental Health Care Coordinator determine necessary.

F: I understand that in order to provide this service to me, the Social Security Administration allows a Representative Payee to collect a fee for serving as my Representative Payee. This fee shall be deducted from my monthly income.

G. Upon termination of my participation in the Representative Payee Program, I understand that any balance in my account with D & L Representative Payee Services will be returned to Social Security Administration for determination of continuing eligibility.

Signed,

_____ _____

Client Date

_____ _____

Legal Representative (Guardian, Conservator, etc.) Date

Advanced Notification of Representative Payee

Name of Wage Earner, Self-Employed Person or SSI Claimant:	Social Security Number:
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 **D & L Representative Payee Services** to be my representative payee.

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.

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 individual 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 (9-94)

SOCIAL SECURITY ADMINISTRATION

STATEMENT OF CLAIMANT OR OTHER PERSON

Name of Wage Earner, Self-Employed Person or SSI Claimant:	Social Security Number:
Name of Beneficiary (if other than above):	Relationship to Wage Earner, Self-Employed Person or SSI Claimant:

Understanding that this statement is for the use of the Social Security Administration, I hereby certify that:

Full Name:
Date of Birth:
Place of Birth:
Mother's Full Name:
Mother's Maiden Name:
Father's Full Name:

Privacy Act Statement

Collection and Use of Personal Information

Public Law 110-328 and section 1631(e) of the Social Security Act, as amended, authorize us to collect this information. The information you provide will be used to determine if you have made a good faith effort to pursue U.S. Citizenship, so that we may make a decision on additional Supplemental Security Income (SSI) benefits.

The information you furnish on this form is voluntary. However, failure to provide the requested information will prevent us from making a timely decision on your benefits.

We generally use the information you supply for the purpose of determining eligibility for benefits. However, we may use it for the administration and integrity of Social Security programs. We may also disclose information to another person or to another agency in accordance with approved routine uses, which include but are not limited to the following:

1. To enable a third party or an agency to assist Social Security in establishing rights to Social Security benefits and/or coverage, including the U.S. Citizenship and Immigration Service in order to verify information provided;

2. To comply with Federal laws requiring the release of information from Social Security records (e.g., to the Government Accountability Office and Department of Veterans' Affairs);

3. To make determinations for eligibility in similar health and income maintenance programs at the Federal, state, and local level; and

4. To facilitate statistical research, audit or investigative activities necessary to assure the integrity of Social Security programs.

We may also use the information you provide in computer matching programs. Matching programs compare our records with records kept by other Federal, state, or local government agencies. Information from these matching programs can be used to establish or verify a person's eligibility for Federally funded or administered benefit programs and for repayment of payments or delinquent debts under these programs.

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 15 minutes to read the instructions, gather the facts, and answer the questions. **SEND THE COMPLETED FORM TO YOUR LOCAL SOCIAL SECURITY OFFICE. The office is listed under U. S. Government agencies in your telephone directory or you may call Social Security at 1-800-772-1213 (TTY 1-800-325-0778).** *You may send comments on our time estimate above to: SSA, 6401 Security Boulevard, Baltimore, MD 21235-6401.* ***Send only comments relating to our time estimate to this address, not the completed form.***

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. I understand that anyone who knowingly gives a false or misleading statement about a material fact in this information, or causes someone else to do so, commits a crime and may be sent to prison, or may face other penalties or both.

SIGNATURE OF PERSON MAKING STATEMENT

Signature *(First name, middle initial, last name) (Write in ink.)*	Date (Month, Day, Year)
Sign Here >	Phone Number (Include Area Code) (423) 464-6565
Mailing Address (Number and Street, Apt. No., PO Box, Rural Route) 111 Durkee Road NE # 54	
City and State Cleveland, TN	Zip Code 37323-6401

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 individual 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)*

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AUTHORIZATION TO OBTAIN PERSONAL & HEALTH CARE INFORMATION

I, the Client/Consumer/Parent/Guardian of:

Client/Consumer Name: _____ SSN: _____ DOB: _____

Authorized D & L Representative Payee Services and its employees to obtain the following information/records:

- ☐ Educational
- ☐ Medical/Dental
- ☐ Individual Program Plan
- ☐ Social
- ☐ Vocational
- ☐ Utility Bills
- ☐ Wages Information
- ☐ Psychological
- ☐ Other (Specify):

_____

This information will be used for the purposes indicated below:

- ☐ Social Security Eligibility
- ☐ Paying My Bills
- ☐ Social Security Re-determination
- ☐ Other (Specify):

_____

This authorization will remain in effect for as long as I am a client with D & L Representative Payee Services or until revoked by me in writing.

_____ _____

Client/Consumer/Parent/Guardian Signature

Date

D & L REPRESENTATIVE PAYEE SERVICES

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FIXED BOARD AND CARE/MEDI-CAL SHARE OF COST DISBURSEMENT AUTHORIZATION

Client's Name DL Number

Name of Facility

, ,

Facility Address

Facility Contact Person Title Phone Number

RATE FOR BOARD AND CARE OR MEDI CAL SHARE OF COST: Effective date is _____ and continuing until the D & L Representative Payee Services is notified, the monthly charge for board and care/medi-cal share of cost is $_____ payable to:

_____

_____

_____

AGREEMENT: I, the authorized facility representative, agree to notify the D & L Representative Payee Services immediately at (626) 869-6565 when the client has been absent for one day.

☐ For Board and Care I agree to refund to the D & L Representative Payee Services a sum equal to the daily rate multiplied by the number of days the conservatee did not reside at the facility during the month.

☐ For Board and Care I agree to refund to the D & L Representative Payee Services the conservatee rent for the month in the event he/she is evicted.

☐ For Share of Cost

CONDUIT PAYEE AVOIDANCE

A conduit payee does not exercise control over the client's Social Security/Supplemental Security Income benefits and cannot fully account for how these benefits were spent. This is not acceptable to Social Security which requires Representative Payees to provide documentation to account for the client's benefits.

You agree to provide D & L Representative Payee Services with copies of the ledger which you track the client's money upon request. If possible also please submit any receipts that the client provides. This can be faxed, e-mailed or mailed to us.

AGREED:

Print name of authorized representative	Authorized signature on behalf of facility	Date

APPROVED:

	Date

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RENTAL/ROOM & BOARD DISBURSEMENT AUTHORIZATION

Name _____ DL Number _____

Name of Apartment Complex or Room & Board _____

Street Address _____ City _____ State _____ Zip _____

Contact Person _____ Title _____ Phone Number _____

RATE FOR RENT: Effective date is _____ and continuing until the D & L Representative Payee Services is notified, the monthly Rent/Room & Board/Room Only is $_____ payable to:

_____

_____

_____

AGREEMENT: I, the authorized facility representative, agree to notify the D & L Representative Payee Services immediately at (626) 869-6565 when the client has given 30 days' notice or we have given the client an eviction notice.

☐ I agree to refund to the D & L Representative Payee Services a sum equal to the daily rate multiplied by the number of days the renter did not reside at the facility during the month.

☐ Room & Board (Must give 30 days' notice unless hospitalized.)

☐ Rent (Must give 30 days' notice unless hospitalized.)

Rental Agreement – HUD Certificate

Please include a copy of your rental agreement or HUD Certificate.

AGREED:

Print name of authorized representative	Authorized representative's signature	Date
Print name of client	Client's signature	Date

DLRPS' APPROVAL:

Print name	Signature	Date

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Subject: Same Day Access to Your Weekly, Bi-Weekly or Monthly Payments

Dear D & L Representative Payee Services Client,

Currently there is a five business day delay between when your check is issued and it arrives to you via the mail. We are now able to provide you your check on the day it is issued via direct deposit.

We strongly encourage you get one of the following cards to facilitate direct deposit. The following are the cards that we recommend for this purpose.

1. Chase Liquid Reloadable Card (from **Chase Bank**) or
2. American Express Bluebird Card (Found at **WALMART**)

Once you get one of these supported cards or if you already have a pre-paid debit card you will need to provide us with the routing and account number. You can fax it to (951) 324-9660 or mail it back to P.O. 1637, Walnut, CA 91788.

If you should have any questions please contact your representative payee Ms. Edwina Donaldson.

Sincerely,

Paul D. Lovette
Executive Manager

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LANDLORD DIRECT DEPOSIT AUTHORIZATION

Authorization for Direct Deposit	
Bank Name: _____ Printed Name on Bank Account: _____ This is a: __ Business __ Personal Bank Account __ I have enclosed is a voided check	
E-Mail Address: _____	
Routing Number:_____	Account Number: _____
Signature:	Date:

I authorize D & L Representative Payee Services (DLRPS) to directly deposit rent payments into the above bank account and I agree to return any money deposited into my account for which I am not authorized to receive due to a client leaving DLRPS services or the Social Security Administration withholds a client's monthly benefits.

THIS SERVICE IS FREE

PHONE: 951.254.3032 FAX: 951.324.9660