Trust Management Services
P.O. Box 498
Glenhaven, CA 95443

INDEPENDENT LIVING INTAKE PACKET

Dear Service Coordinator,

Attached you will find our 4 page intake form and the required releases. Please follow the instructions carefully. After you have completed the intake forms and gathered the required signatures, all of the documents should be mailed to the address above. We MUST HAVE the original signatures - faxes will not work. Once we have received the required paperwork and find it to be complete we will submit a change of payee application to Social Security.

Authorization for Payeeship: Please use ink when completing this form. Complete both the consumer's name SSN and SSA Claim number in the top right corner. (The SSA claim number is the number under which the consumer is receiving SSA benefits) If the consumer signs with X or mark there must be 2 witnesses signature at the bottom portion of this form.

TMS - Consent to Exchange Information: Please use ink when completing this form. This form was developed so we can obtain and exchange information about the consumer for the purposes of either acting as the payee or paying their bills. Please fill in the Consumer's Name, Social Security Number and date of birth at the top of this form. Review this form with the consumer explaining all types of information we may ask for and with whom it may be shared. If the consumer objects to any you should place a line through that particular item(s). Have the consumer sign and date the form. If the consumer signs with an X or mark 2 witnesses' signatures are required at the bottom of this form.

Authorization for Social Security to Obtain Personal Information: This is a Social Security form and is requested upon intake. Please enter consumer's name and SSN on the first line. Have consumer sign the middle section by the arrow. If the consumer signs with an X or mark 2 witnesses' signatures are required at the bottom of this form.

Budget Worksheet: This page is used to tells us who to pay, where to mail payment and how often money is sent. We run checks each working day. We are closed all federal holidays. We will also be closed the last working day of the month to review the next month budgets. If your consumer wants money sent to them on a particular day of the month and that day falls on a weekend or holiday the check will be send out the working day before.

Please complete the consumer's name and SSN as well as the SSA claim number if consumer is receiving SSA. When working on a budget for a consumer, you need to know how much money the consumer gets each month. Next you should write the amounts received in the income section. Now it is time to tell us what there bills are. Rent, Utilities, Food, etc. For food and personal spending, please advise both how often your consumer would like these funds mailed (weekly, biweekly, monthly, semi-monthly or on a specific day of the month).

When figuring out the amounts for food and personal spending, please calculate based on a 5 week month - we don't want to run short! **Make sure that total monthly expenses do not exceed total monthly income received.**

The consumer, with help from there ILS or SLS agency, should contact any utility company you have indicated on this form and request the mailing address of their bill be changed to our address **PO Box 498, Glenhaven, CA 95433**. The support agency should remind the consumer that if they continue to receive their bill this means TMS is not and they should again contact the utility company to request a change of address.

TMS Independent Living Payee Intake Form This is a 4 page form requesting biographical information about your consumer. Please send copies of requested documents when instructed. Please fill in all areas. If any area does not apply, draw a line through it and write N/A.

After all forms have been completed they should be mailed to TMS at the address above.

If you have any questions feel free to contact your staff at TMS

Janet Graser E-mail Janet@trustmgmtservices.com

Janet is working with Redwood Coast consumers living with either Board & Care or licensed ICF facilities or living independently.

Current phone numbers can be found on our Web site.
Visit us at www.trustmgmtservices.com.

Advance Notification of Representative Payment

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 ______________________________ 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.

Signature	Date

Witnesses are required <u>only</u> 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)

Authorization for Payeeship
Advance Notification of Representative Payment

Client Name ______________________ SSN ______________________

SSA Claim # ______________________

AUTHORIZATION FOR PAYEESHIP

I ______________________________ hereby authorize Trust Management Services (TMS) to file an application for payeeship and to become payee for any SSA/SSA benefits I may be eligible to receive. I understand these benefits will be administered by Trust Management Services.

I hereby consent and authorize Trust Management Services and the Social Security Administration to disclose benefits eligibility payment information about me for use in applying for any Social Security Benefits, Supplemental Security Benefits, Railroad benefits, Veterans benefits, Civil Service Annuity benefits, and Black Lung benefits I may be eligible to receive as well as for planing and providing services for me. This authorization will remain in effect for the duration of time for which Trust Management Services is my representative payee.

NEED FOR REPRESENTATIVE PAYEE

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SSA has selected Trust Management Services to be my representative payee.

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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.

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.

Client Signature ______________________ Date ______________________

Legal Representative Signature ______________________ Date ______________________

Witnesses are required only if this statement has been signed by a (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 address.

1.) Signature of Witness	2.) Signature of Witness
Address (Number and Street, City, State, Zip Code)	Address (Number and Street, City, State, Zip Code)

Trust Management Services

P.O. Box 498 Glenhaven, CA 95443

Consent to Exchange Information

I, the Consumer/Parent/Guardian or Conservator of:

CONSUMER Name: ______________________________

SSN: ______________________________

Date of Birth: ______________________________

Authorized TMS, and it's employees to obtain the following type of information/records:

____ Educational
____ Medical/Dental
____ Individual Program Plan
____ Social
____ Vocational
____ Utility Bills
____ Wages information
____ Psychological
____ Other (Specify)

____

This information shall be used for the purposes indicated below:

____ Social Security Eligibility
____ Social Security Re-determination
____ Other (Specify) ______________________________
____ Paying my bills
____ Social Security CDR

This authorization shall be valid for a period of one year form the date signed or until ____________ revoked in writing.

Consumer Signer: ______________________________

Date: ______________________________

Witnesses are required only if this statement has been signed by a (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 address.

1.) Signature of Witness	2.) Signature of Witness
Address (Number and Street, City, State, Zip)	Address (Number and Street, City, State, Zip)

AUTHORIZATION FOR THE SOCIAL SECURITY ADMINISTRATION TO OBTAIN PERSONAL INFORMATION

Authorizing Person (Person about whom information is being requested)	Social Security Number

Claimant/Beneficiary (If other than authorizing person)	Claimant's/Beneficiary's Social Security Number

I authorize any public or private custodian of records to disclose to the Social Security Administration any records or information about me. In the case of a minor or incapable person, I, as guardian or representative, authorize the same disclosure of records about the person I represent.

Authorizing Person's Signature

SIGN HERE →

Mailing Address	City and State	ZIP Code

Your authorization does not ordinarily have to be witnessed. However, if you have signed by mark (X), two witnesses to the signing who know you must sign below giving their full addresses.

1. Signature of Witness	2. Signature of Witness
Address (Number, Street, City, State, ZIP Code)	Address (Number, Street, City, State, ZIP Code)

Printed on recycled paper

TMS Independent Living Payee Intake Form

____
First Name   Last Name   Mi

SSN: ______________________________

SSA Claim #: ________________________-_______

UCI#: ______________________________

Sex: _________ DOB: _____________ Place of Birth ______________________ State ______

Legally blind?: (Yes / No) (Circle One) **Deaf?**: (Yes / No) (Circle One)

Is consumer conserved? (Yes / No) Circle One

If consumer is conserved, please attach copy of conservatorship papers and fill in below:

Name____ Phone: (_____) _____-____________

Living Arrangements

Address: ____

City: ____________________________________ St: _____ Zip: _______________

Phone: (_____) _____-____________

Description of Living Arrangements

(Check one)

___ Alone in own apt/home

___ Sharing apt/home with roommates

___ Paid roommate in home (How much rent does paid roommate pay? $___________)

Date Moved In: ______________________

(mo/yr)

Landlord name: ____

City: ____________________________________ St: _____ Zip: _______________

Phone: (_____) _____-____________

Roommate Information

1st Roommate Name: ______________________________ DOB or SSN: ______________

Is roommate on SSI? (Yes / No) (Circle One) Is roommate paid roommate? (Yes / No) (Circle One)

2nd Roommate Name: ______________________________ DOB or SSN: ______________

Is roommate on SSI? (Yes / No) (Circle One) Is roommate paid roommate? (Yes / No) (Circle One)

#3 Roommate Name: ______________________________ DOB or SSN: ______________

Is roommate on SSI? (Yes / No) (Circle One) Is roommate paid roommate? (Yes / No) (Circle One)

If additional space is required, use back of page

Employment Information

Employer Name: ______________________________ Date Started Working __________

Employer Mailing Address: ____

City: ______________________________ St: _____ Zip: __________

Phone: (______) ______ - __________ Fax: (______) ______ - __________

Contact Name: ______________________________

How often paid: Weekly / Every 2 Weeks / Twice a Month / Monthly / Piece Work (Circle One)

Last Date Paid: ______________________________ (mo/day/year)

Paid by the: Hour / Piece (Circle One)

Rate of Pay: $__________ Average Check $__________

Resources: Cash on Hand

Cash on Hand $____________________ as of ____________ (mo/day/yr)

Resources: Checking Account

Bank Name: ______________________________

Acct. # ____________ Balance $ __________ as of date ________

Interest Bearing: Monthly / Quarterly / None (circle one)

Please attach copy of current bank statement

Resources: Savings Account

Bank Name: ______________________________

Acct. # ____________ Balance $ __________ as of date ________

Interest Bearing: Monthly / Quarterly / None (circle one)

Please attach copy of current bank statement

Resources: Special Needs Trust

Trustee Name ______________________________

Address: ______________________________

City: ______________ St: _____ Zip: __________

Phone: (_____) _____ - _______

Please attach copy of Trust Document

Resources: Burial Account

Where: ______________________________

Amount/Balance $ ____________ Revocable / Irrevocable (circle one)

Address: ______________________________

City: ______________ St: _____ Zip: __________

Phone: (_____) _____-_______ **Please attach copy of Burial Document**

ILS / SLS Agency Involved with Consumer

Agency Name: ______________________________

Support Staff's Name: ______________________________

Address: ______________________________

City: ______________________________ St: _____ Zip: ______________

Phone: (_____) _________-_____________ Fax: (_____) _________-_____________

Email: ______________________________

Service Coordinator Involved with Consumer

Name: ______________________________

Office Location: ______________________________

Address: ______________________________

City: ______________________________ St: _____ Zip: ______________

Phone: (_____) _________-_____________ Fax: (_____) _________-_____________

Email: ______________________________

BUDGET SHEET

Consumer Name: __________
SSN: __________
SSA Claim #: __________

Income :

SSI $ __________
SSA $ __________
Other $ __________

____
Benefit Name and Claim number

Total Income $ __________

Expenses:	**Amount**	**Who is paid, Address & Phone #**	**Detailed Description: Inculde account #**
Rent			
Utilities Gas			
Utilities Electric			
Utilities Phone			
Utilities Cable TV			
Food			
Personal Spending			
Other			
Other			

Total Expenses __________

SOCIAL SECURITY ADMINISTRATION

STATEMENT OF CLAIMANT OR OTHER PERSON

NAME OF WAGE EARNER, SELF-EMPLOYED PERSON, OR SSI CLAIMANT	SOCIAL SECURITY NUMBER
NAME OF PERSON MAKING STATEMENT *(If other than above wage earner, self-employed person, or SSI claimant)*	RELATIONSHIP TO WAGE EARNER, SELF-EMPLOYED PERSON, OR SSI CLAIMANT

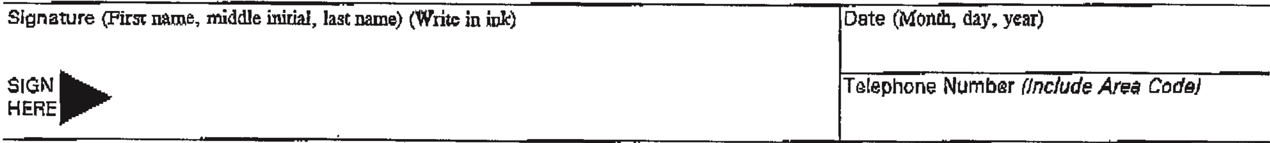
Understanding that this statement is for the use of the Social Security Administration, I hereby certify that -

PERMISSION TO CONTACT FINANCIAL INSTITUTIONS: YES______ NO______

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. You may send comments on our time estimate above to: SSA, 1338 Annex Building, Baltimore, MD 21235-0001. 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) SIGN HERE	Date (Month, day, year) Telephone Number *(Include Area Code)*
Mailing Address (Number and street, Apt. No., P.O. Box, Rural Route)	
City and State	ZIP Code

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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