Trust Management Services
P.O. Box 601676
Sacramento, CA 95860-1676

BOARD & CARE 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 gather 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 consumers signs with an X or a mark, there must be 2 witness signatures 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 item, 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 a mark, 2 witness 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 the Consumer's Name and SSN on the first line. Have the consumers sign the middle section by the arrow. IF the consumer signs with an X or a mark, 2 witness signatures are required at the bottom of this form.

TMS Board and Care 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. On the 3rd page we are asking how the Personal and Incidental money for the consumer should be issued. If the care home is holding a P&I account for their consumers they will have to send us copies of the P&I ledger for each consumer before additional funds will be released. We will not automatically send the P&I out every month.

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:

Eric Brown, Director Payee Programs E-mail Eric@trustmgmtservices.com

Valley Mountain Regional Center:

Shakira Brewer, Sr. Account Manager E-Mail Shakira@trustmgmtservices.com
Consumer Last Names A-I

Fidelina Lara – Consumer Last Names J-Z E-Mail Fidelina@trustmgmtservices.com

Current phone numbers can be found on our website.
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 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 and Street, City, State and ZIP Code)	Address (Number and Street, City, State and ZIP Code)

Form **SSA-4164** (9-1994) (EF 8-2000)
Destroy prior editions

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 SSI/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 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 planning 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
The Social Security Administration (SSA) had 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 Trust Management Services 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.

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 an (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

PO Box 601676, Sacramento, CA 95860-1676

Consent to Exchange Information

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

CONSUMER Name: _____

SSN: _____

Date of Birth: _____

Authorize TMS, and its employees to obtain the following type of information/records:

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

This information shall be used for the purposes indicated below:

☐ Social Security Eligibility	☐ Paying my bills
☐ Social Security Re-determination	☐ Social Security CDR

☐ Other (Specify) _____

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

Consumer signer: _____

Date: _____

Witnesses are required only if this statement has been signed by an (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)

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** →		Date
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)

TMS B&C Intake Form

First Name _____ Last Name _____ Mi _____

SSN: _____

SSA Claim #: _____ - _____

UCI#: _____

Sex: _____ DOB: _____ Place of Birth _____ State _____

Legally Blind: Yes No (Check One) **Deaf:** Yes No (Check One)

Is consumer conserved? Yes No (Check One)

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

Name: _____ Phone: _____

Living Arrangements when in Board & Care

Licensed name of facility: _____

Physical Address: _____

City: _____ St: _____ Zip: _____

Phone: _____

Mailing Address: _____

City: _____ St: _____ Zip: _____

Msg/Cell/Phone: _____

Date Moved In: _____ (mo/yr)

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 (Check One)

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

Paid by the: Hour Piece (Check One)

Rate of Pay: $ _____ Average Check: $ _____

Resources: Cash on Hand

Cash on Hand: $ _____

Resources: Checking Account

Bank Name: _____

Acct. # _____ Balance: $ _____ as of date _____

Interest Bearing: Monthly Quarterly None (Check One)

Please attach copy of current bank statement

Resources: Savings Account

Bank Name: _____

Acct. # _____ Balance: $ _____ as of date _____

Interest Bearing: Monthly Quarterly None (check 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 (Check One)

Address: _____

City: _____ St: _____ Zip: _____

Phone: _____

Please attach copy of Burial document

P&I

Account Balance at Care Home: $ _____ as of _____

_____ Care Home will receive and administer the P&I funds

_____ Consumer wants to receive his /her own P&I funds (if this is selected consumer must have a bank account.)

Service Coordinator Involved with Consumer

Name: _____

Office Location: _____

Address: _____

City: _____ St: _____ Zip: _____

Phone: _____ Fax: _____

Email: _____

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)	Date (Month, day, year)
SIGN HERE ▶	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)