HARBOR REGIONAL CENTER
BOARD & CARE INTAKE CHECKLIST

☐ SSA-4164-Advance Notification

Please use ink when completing this form. Include the client's name, SSN and SSA Claim Number in the top right corner. If client signs with an X or a mark, there must be 2 witness signatures at the bottom of the form.

☐ SSA-8510- Auth for Info

☐ SSA-3288- Consent Release of Info

SSA- 8510 & SSA-3288 are Social Security forms and are required upon intake. Please enter the client's Name and SSN on the first line. Have the client sign. If the client signs with an X or a mark, 2 witness signatures are required at the bottom of the form.

☐ Intake Form

TMS' Intake Form requests biographical information about your client. Please send copies of requested documents when instructed. Please complete all sections of the form. If a section does not apply, draw a line through it and write N/A.

☐ Admission Agreement

Nondisclosure of Employment and/or Resource Information may result in overpayments and/or loss of benefits

☐ *Copies of most recent paystubs

☐ *Copy of Conservatorship paperwork

☐ *Copy of most recent bank statement

☐ *Copy of Burial Contract

☐ *Copy of Special Needs Trust paperwork (accounting may be needed during a social security audit)

☐ *Copy of most recent CalAble statement

☐ *RSP Direct Deposit Form

☐ Submit POS

*** Service Coordinators-please send a Purchase of Service (POS) to your Fiscal Department for the payee fee when you mail the Payee Packet to our office. TMS will not bill for payee fees until a benefit is received by our agency.

*if applicable

Once you have completed the checklist above, please mail original (wet signatures) intake packet to:

Trust Management Services

PO BOX 601676

Sacramento, CA 95860

Contact Eric Brown, Director of Payee Programs if you have questions regarding the completion of this packet.

(916) 394-1062 or by email eric@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 Trust Management Services 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 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

Consent for Release of Information

Form Approved
OMB No. 0960-0566

Instructions for Using this Form

Complete this form only if you want us to give information or records about you, a minor, or a legally incompetent adult, to an individual or group (for example, a doctor or an insurance company). If you are the natural or adoptive parent or legal guardian, acting on behalf of a minor child, you may complete this form to release only the minor's non-medical records. We may charge a fee for providing information unrelated to the administration of a program under the Social Security Act.

NOTE: Do not use this form to:

- Request the release of medical records on behalf of a minor child. Instead, visit your local Social Security office or call our toll-free number, 1-800-772-1213 (TTY-1-800-325-0778), or
- Request detailed information about your earnings or employment history. Instead, complete and mail form SSA-7050-F4. You can obtain form SSA-7050-F4 from your local Social Security office or online at www.ssa.gov/online/ssa-7050.pdf.

How to Complete this Form

We will not honor this form unless all required fields are completed. An asterisk (*) indicates a required field. Also, we will not honor blanket requests for "any and all records" or the "entire file." You must specify the information you are requesting and you must sign and date this form. We may charge a fee to release information for non-program purposes.

- Fill in your name, date of birth, and social security number or the name, date of birth, and social security number of the person to whom the requested information pertains.
- Fill in the name and address of the person or organization where you want us to send the requested information.
- Specify the reason you want us to release the information.
- Check the box next to the type(s) of information you want us to release including the date ranges, where applicable.
- For non-medical information, you, the parent or the legal guardian acting on behalf of a minor child or legally incompetent adult, must sign and date this form and provide a daytime phone number.
- If you are not the individual to whom the requested information pertains, state your relationship to that person. We may require proof of relationship.

PRIVACY ACT STATEMENT

Section 205(a) of the Social Security Act, as amended, authorizes us to collect the information requested on this form. We will use the information you provide to respond to your request for access to the records we maintain about you or to process your request to release your records to a third party. You do not have to provide the requested information. Your response is voluntary; however, we cannot honor your request to release information or records about you to another person or organization without your consent. We rarely use the information provided on this form for any purpose other than to respond to requests for SSA records information. However, the Privacy Act (5 U.S.C. § 552a(b)) permits us to disclose the information you provide on this form in accordance with approved routine uses, which include but are not limited to the following:

1. To enable an agency or third party to assist Social Security in establishing rights to Social Security benefits and or coverage;
2. To make determinations for eligibility in similar health and income maintenance programs at the Federal, State, and local level;
3. To comply with Federal laws requiring the disclosure of the information from our records; and,
4. To facilitate statistical research, audit, or investigative activities necessary to assure the integrity of SSA programs.

We may also use the information you provide when we match records by computer. Computer matching programs compare our records with those of other Federal, State, or local government agencies. We use information from these matching programs to establish or verify a person's eligibility for Federally-funded or administered benefit programs and for repayment of incorrect payments or overpayments under these programs. Additional information regarding this form, routine uses of information, and other Social Security programs is available on our Internet website, www.socialsecurity.gov, or at your local Social Security office.

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 3 minutes to read the instructions, gather the facts, and answer the questions. **SEND OR BRING THE COMPLETED FORM TO YOUR LOCAL SOCIAL SECURITY OFFICE. You can find your local Social Security office through SSA's website at www.socialsecurity.gov. Offices are also listed under U.S. Government agencies in your telephone directory or you may call 1-800-772-1213 (TYY 1-800-325-0778).** You may send comments on our time estimate above to: SSA, 6401 Security Blvd., Baltimore, MD 21235-6401. ***Send only comments relating to our time estimate to this address, not the completed form.***

Social Security Administration

Form Approved
OMB No. 0960-0566

Consent for Release of Information

You must complete all required fields. We will not honor your request unless all required fields are completed. *(*Signifies a required field. **Please complete these fields in case we need to contact you about the consent form).*

TO: Social Security Administration

***My Full Name**	***My Date of Birth (MM/DD/YYYY)**	***My Social Security Number**

I authorize the Social Security Administration to release information or records about me to:

***NAME OF PERSON OR ORGANIZATION:**	***ADDRESS OF PERSON OR ORGANIZATION:**
Trust Management Services	P.O. Box 601676, Sacramento, CA 95860

***I want this information released because:** I want Trust Management Services to apply for payeeship of my benefits.

We may charge a fee to release information for non-program purposes.

***Please release the following information selected from the list below:**
Check at least one box. We will not disclose records unless you include date ranges where applicable.

1. ☒ Verification of Social Security Number
2. ☒ Current monthly Social Security benefit amount
3. ☒ Current monthly Supplemental Security Income payment amount
4. ☐ My benefit or payment amounts from date ____________ to date ____________
5. ☐ My Medicare entitlement from date ____________ to date ____________
6. ☐ Medical records from my claims folder(s) from date ____________ to date ____________
   If you want us to release a minor child's medical records, do not use this form. Instead, contact your local Social Security office.
7. ☐ Complete medical records from my claims folder(s)
8. ☐ Other record(s) from my file (We will not honor a request for "any and all records" or "the entire file." You must specify other records; e.g., consultative exams, award/denial notices, benefit applications, appeals, questionnaires, doctor reports, determinations.)

I am the individual, to whom the requested information or record applies, or the parent or legal guardian of a minor, or the legal guardian of a legally incompetent adult. I declare under penalty of perjury (28 CFR § 16.41(d)(2004) that I have examined all the information on this form and it is true and correct to the best of my knowledge. I understand that anyone who knowingly or willfully seeking or obtaining access to records about another person under false pretenses is punishable by a fine of up to $5,000. I also understand that I must pay all applicable fees for requesting information for a non-program-related purpose.

***Signature:** ______________________ ***Date:** ____________

****Address:** ______________________ ****Daytime Phone:** ____________

Relationship (if not the subject of the record): ______________________ ****Daytime Phone:** ____________

Witnesses must sign this form ONLY if the above signature is by mark (X). If signed by mark (X), two witnesses to the signing who know the signee must sign below and provide their full addresses. Please print the signee's name next to the mark (X) on the signature line above.

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)

TMS Board & Care Intake Form

Client Information

First Name ______ Last Name ______ MI ______

SSN: ______ SSA Claim #: ______

UCI #: ______ Sex: ______

DOB: ______ Place of Birth: ______ State: ______

Mother's Name: ______ Mother's Maiden Name: ______

Mother's DOB: ______ Father's Name: ______ Father's DOB: ______

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

Conserved: ☐ Yes ☐ No **If client is conserved, please attach a copy conservatorship papers and fill below:**

Conservators Name: ______ Conservators Phone#: ______

Board & Care Facility: Date Moved In: ______ (Month/Day/Year)

Licensed Name of Facility: ______

License/Facility #: ______

Physical Address: ______

City: ______ State: ______ Zip: ______

Phone #: ______

Mailing Address: ______

City: ______ State: ______ Zip: ______

*** Include copy of Full Admission Agreement**

Employment Information

Employer Name: ______________________________ Start Date: ______________

Employer Mailing Address: ____

City: ________________________ State: ____________ Zip: ______________

Contact Name: ______________________ Phone #: ______________________

How often Paid: (Check One) ☐ Weekly ☐ Every 2 Weeks ☐ Twice a Month ☐ Monthly ☐ Piece Work

Paid by the: (Check One) ☐ Hour ☐ Piece Last Date Paid: ____________ (Month/Day/Year)

Rate of Pay $: ____________________ Average Check: ____________________

*** Paycheck stubs must be sent to TMS for reporting to Social Security.**

Nondisclosure of Employment and/or Resource Information may result in overpayments and/or loss of benefits

Resources: Checking Account

Bank Name: ______________________ Account #: ______________________

Balance $ ______________ as of date: ________________ (Month/Day/Year)

*** Attach copy of current bank statement**

Resources: Savings Account

Bank Name: ______________________ Account #: ______________________

Balance $ ______________ as of date: ________________ (Month/Day/Year)

*** Attach copy of current bank statement**

Resources: Cash on hand

Cash on Hand: ____________________ as of ______________ (Month/Day/Year)

Receiving Cal Fresh: ☐ Yes ☐ No (Check One)

Resources: Special Needs Trust

Trustee Name: ____________________

Address: ____________________

City: ____________________ State: ____________ Zip: ____________

Phone #: ____________________

*** Attach copy of trust document**

Resources: Burial Account

Where: ____________________

Amount/Balance $ ____________________ ☐ Revocable ☐ Irrevocable (Check One)

Address: ____________________

City: ____________________ State: ____________ Zip: ____________

Phone #: ____________________

*** Attach copy of burial document**

Resources: Cal Able Account

Account #: ____________________ Date Opened: ____________ (Month/Day/Year)

Balance $ ____________________ as of date: ____________ (Month/Day/Year)

*** Attach current Cal Able statement**

Additional Resources: (benefits other than SSI & SSA)

Benefit: ____________________ Claim #: ____________ Benefit Amount $ ____________

Benefit: ____________________ Claim #: ____________ Benefit Amount $ ____________

Benefit: ____________________ Claim #: ____________ Benefit Amount $ ____________

REGIONAL CENTER SERVICE COORDINATOR

Name ____

Office Location

Address:____

City: ____________________________________ State: __________________ Zip: ____________________

Phone #: ________________________________ Fax: ____

Email Address: ____

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

July 17, 2022

Dear Residential Service Provider,

Trust Management Services is now offering the option of electronic fund transfers (EFT) for board & care and consumer P&I payments. You still have the option of receiving a paper check if you prefer.

Advantages of EFT Payments:

- EFT payments are more secure.
- EFT payments are environmentally friendly.
- EFT payments are more efficient.
- You will receive an email notification when a payment is issued.

To sign up for EFT/ACH payments:

1. Complete the attached Enrollment Form and return it along with a copy of a voided check(s) to Trust Management Services at: **PO Box 601676, Sacramento CA 95860-1676**, **or via fax 916-399-9421 or email by to eric@trustmgmtservices.com:**

- (*If you prefer to send in your bank account information via secure email, please let us know and we will initiate a secure email link upon your request)*.

2. Upon receipt of complete enrollment information, TMS' will send an email to the email address provided on the Enrollment Form confirming enrollment is complete.

Email Notification:

Trust Management Services will send you a secure email notification whenever you are paid electronically. The email address that you provide on the Enrollment Form will be the email address used for the notification. The password to open the email is **TMS_ACH** (All caps).

We look forward to updating your account with this very easy and simple process. If you have any questions, please contact me at 916-394-1062 or via email at eric@trustmgmtservices.com.

Thanks in advance for your support and partnership.

Eric Brown

Eric Brown
Director, Payee Programs

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

EFT/ACH Enrollment Form - Authorization Agreement

Provider Name: ______________________________

Provider Mailing Address: ______________________________

Provider Physical Address: ______________________________

1. **Board & Care Payments:**

   - Financial Institution Name: ______________________________
   - Account Type: ______________________________(Checking or Savings)
   - **TMS is unable to send EFT/ACH payments to Credit Union Savings Accounts*
   - Bank account #______________________________ (located on the right side of check).
   - ABA/bank routing #______________________________ (located on the left side of check).
   - Email address for payment confirmations______________________________

   ☐ Copy of Voided Check is attached.

2. **Consumer P&I Payments:**

   - Financial Institution Name: ______________________________
   - Account Type: ______________________________(Checking or Savings)
   - **TMS is unable to send EFT/ACH payments to Credit Union Savings Accounts*
   - Bank account #______________________________ (located on the right side of check).
   - ABA/bank routing #______________________________ (located on the left side of check).
   - Email address for payment confirmations______________________________

   ☐ Copy of Voided Check is attached.

Provider Contact: ______________________________

Title: ____________________ Contact Phone Number: ____________________

Contact Email Address: ______________________________

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

Authorization Agreement – *Please read and sign your name below*.

I hereby authorize Trust Management Services to initiate credit entries to the account(s) at the bank(s) listed above for all payment types noted above. This agreement will remain in effect until I notify Trust Management Services of the desire to cancel or change this service or until Trust Management Services' notifies me that this service has been terminated. I understand I must allow reasonable time for my instructions to be executed. I authorize and request the bank(s) listed above to accept and credit entries by Trust Management Services to such account (s) and to credit the same to such account.

Trust Management Services will not debit or deduct funds directly from my account without permission. Trust Management Services will seek permission to debit my back account(s) for any adjustments or corrections to resolve duplicate payments or erroneous payments. If an electronic debit is unsuccessful, Trust Management Services will notify me in writing to reach an alternative arrangement for reimbursement.

Authorized Signature:

By signing below, I hereby agree that I have read and agree to the terms and conditions stated above. Furthermore, the undersigned certifies that the information provided is true and accurate in all respects and that he/she has been duly authorized by all necessary and appropriate action.

Signature of Person Submitting Enrollment: ____

Printed Name of Person Submitting Enrollment: ____

Printed Title of Person Submitting Enrollment: ____

Submission Date: _____________________

Telephone: (916) 394-1062 • Fax: (916) 399-9421
E-mail: eric@trustmgmtservices.com
www.trustmgmtservices.com