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 are completed they should be mailed to TMS at the address above.

*Please note that it is the policy of TMS to only provide representative payee services to consumers with a POS from one of the 5 regional centers we serve.

Please send a Purchase of Service (POS) to your Accounting 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 you have any questions feel free to contact your staff at TMS:

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

**Harbor Regional Center:**

Lynn Houchin E-mail Lynn@trustmgmtservices.com

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

## 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<br>**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: _____