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

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 gather the required signatures, all of the documents should be mailed to the address above. We MUST HAVE 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 client's name, SSN and SSA Claim Number in the top right corner. (The SSA claim number is the number under which the client is receiving SSA benefits) If the client 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 client for the purposes of acting as the payee or paying their bills. Please fill in the client's name, Social Security Number and Date of Birth at the top of this form. Review this form with the client explaining the types of information we may ask for and with whom it may be shared. If the client objects to any item, you should place a line through that particular item(s). Have the client sign and date the form. If the client 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 client's Name and SSN on the first line. Have the client sign the middle section by the arrow. If the client signs with an X or a mark, 2 witness signatures are required at the bottom of this form.

Budget Worksheet: This page is used to tell us who to pay, where to mail payment and how often money is to be sent. We run checks each business day. We are closed all Federal holidays. We will also be closed the last working day of the month to review the next month's budgets. If your client 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 sent out the working day before.

Please complete the client's name and SSN as well as the SSA claim number if the client is receiving SSA. When working on a budget for a client, you need to know how much money the client gets each month. Next you should write the amount received in the income section. Please give your best estimate for the monthly amount spent on: rent, utilities, food, etc. For food and personal spending, please advise both how often your client 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 – as we don't want to run short on funds! **Make sure that the total monthly expenses do not exceed the total monthly income received.**

Theclient, with help from their 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 601676, Sacramento, CA 95860.** The support agency should remind the client 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 client. 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:

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

Tri-Counties Regional Center:

Evie Powell - Client Last Names A-G E-Mail Evie@trustmgmtservices.com

Mattie Clegg - Client Last Names H-O E-Mail Mattie@trustmgmtservices.com

Marie Holland- Client Last Names P-Z E-Mail Marie@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

Consent to Exchange Information

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

CLIENT 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.

Client 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 Independent Living Payee 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 client conserved? ☐ Yes ☐ No (Check One)

If client 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

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 (Check One)

2nd Roommate Name: _____ DOB or SSN: _____

Is roommate on SSI? ☐ Yes ☐ No (Check One)

3rd Roommate Name: _____ DOB or SSN: _____

Is roommate on SSI? ☐ Yes ☐ No (Check 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 (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: _____ as of _____ (mo/day/yr)

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

ILS / SLS Agency Involved with Client

Agency Name: _____

Support Staff's Name: _____

Address: _____

City: _____ St: _____ Zip: _____

Phone: _____ Fax: _____

Email: _____

Service Coordinator Involved with Client

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 _____

REQUEST FOR TRUST MANAGEMENT SERVICES TO PROVIDE REPRESENTATIVE PAYEE SERVICE

This form should only be completed if a determination has been made that the client is not capable of managing their own funds.

PLEASE COMPLETE IN FULL

Client Name: _____
Last First M.I.

Soc Sec #: _____ DOB: _____ UCI: _____

Valid Contact Number for Client (**Social Security Requirement)**:_____

☐ This Client is conserved. Conservatorship must be limited to be of person only. Conservator must have no control of finances and must be unwilling to provide payee service.

CRITERIA FOR ELIGIBILITY (choose one):

☐ This Client is in out-of-home placement and their parent/conservator/payee is unreliable in paying for placement, and no other family members or friends are capable of reliably performing this service.

☐ This Client is in out-of-home placement and their parent/conservator/payee is not living in the TCRC service area, and there are no other family members or friends capable of reliably performing this service who reside in the TCRC service area.

☐ This Client lives independently in the community and has previously demonstrated a lack of money management skills, or a doctor has determined that the Client is incapable of reliably managing money.

☐ Client's parent/conservator/payee has used SSI/SSA money for their own use rather than to meet the needs of the Client, and no other family members or friends are capable of reliably performing this service.

Social Security Requirement: Please give a specific reason why the Client requires a payee:

_____
_____
_____
_____

_____ _____

Service Coordinator (Signature) Date

_____

Service Coordinator (Type Name)