Integrity Representative Payee Services, Inc.

Overview
Integrity Representative Payee Services has been assisting clients since 2007. Our organization provides assistance to any individual who is unable to handle their personal finances, or in some cases simply doesn't want to handle their personal finances. Clients are referred to us because there isn't a family member or friend who is willing, able, and trustworthy enough to do this for them. Sadly, many of our clients have been exploited in the past. In other cases, managing income and expenses has put a strain on a family or personal relationship, and it helps to have an objective third party take this over. Referrals are typically called, emailed, or faxed to us from the Department of Social Services, community mental health agencies, concerned friends and family members, or sometimes come directly from the client. We manage income sources including, but not limited to, Social Security Retirement, Social Security Disability Income, Supplemental Security Income, VA Pension, Civil Service (OPM) Pension, Railroad Retirement, current employment income, pension from previous employment, lump sums, reverse mortgages, alimony, and child support.

Who We Are
Integrity Representative Payee Services, Inc., is a licensed and bonded 501(c)3 nonprofit organization serving clients in Virginia and North Carolina.

What We Do
Our organization serves clients in one of two capacities. In some cases, a client is required to have a person or organization manage their income. The Social Security Administration and the VA are the income sources most likely to determine this. Social Security terminology for this is requiring a Representative Payee. The VA calls this requiring a Federal Fiduciary. So with clients who are required by the agency who is also the income source, we manage the income, pay the expenses, and follow the rules of the income source.
For any individual not described above, we serve as a Bookkeeper. In this capacity, we still manage a client's income and expenses. However, the client is the decision maker. They are able to start, change, or stop service at any time. This enables them to retain the freedom to have control of their money, while also enabling them to have professional assistance with managing their income and expenses.
With all of our clients, our goal is to manage their income and expenses in an efficient, timely manner. We handle the payment of a client's monthly bills, and use remaining funds to provide for food and other regular expenses throughout the month. Our service benefits not only the client, but also the caretakers and caseworkers involved in looking out for the client's best interests.

Oversight
The Integrity Representative Payee Services Board of Directors provides a wealth of expertise in nonprofit, social service, accounting, and information technologies, ensuring that we operate in an effective manner. In addition, the Social Security Administration and the Veterans Administration are able to review our accounting of client funds for accuracy and policy compliance.

How To Contact Us
If you have a client that can benefit from our services, you can reach our administrator, Ms. Cara Hall, directly at (434) 770-9962. The client intake package we have include can be faxed to us at (703) 842-8950. Feel free to contact us with any questions or to schedule an appointment to review our services in more detail.

Form Approved
OMB No. 0960-0045

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 –

The Social Security Administration has determined that I need a representative payee to assist me with managing my social Security and/or Supplemental Security Income payments. In the event that The Social Security Administration is not able to locate a family member or an appropriate person or other organization to serve as my representative payee, SSA may contact Integrity Representative Payee Services, Inc., at (434) 770-9962, to ascertain if the organization would be willing to serve as my payee.
It has been explained to me that SSA is not normally authorized to discuss my case with a third party (including Integrity Representative Payee Services, Inc.) without my approval. Therefore, I hereby authorize The Social Security Administration to contact Integrity Representative Payee Services, Inc. on my behalf so that it may file as my representative payee.

We may also use the information you give us when we match records by computer. Matching programs compare our records with those of other Federal, State, or local government agencies. Many agencies may use matching programs to find or prove that a person qualifies for benefits paid by the Federal government. The law allows us to do this even if you do not agree to it.

Explanations about these and other reasons why information you provide us may be used or given out are available in Social Security offices. If you want to learn more about this, contact any Social Security office.

The **Paperwork Reduction Act of 1995** requires us to notify you that this information collection is in accordance with the clearance requirements of section 3507 of the Paperwork Reduction Act of 1995. We may not conduct or sponsor, and you are not required to respond to, a collection of information unless it displays a valid OMB control number.

TIME IT TAKES TO COMPLETE THIS FORM
We estimate that it will take you about 15 minutes to complete this form. This includes the time it will take to read the instructions, gather the necessary facts and fill out the form. If you have comments or suggestions on this estimate, write to the Social Security Administration, ATTN.: Reports Clearance Officer, 1-A-21 Operations Bldg., Baltimore, MD 21235-0001. **Send only comments relating to our "time it takes" estimate.**

I know that any one who makes or causes to be made a false statement or representation of material fact in an application
or for use in determining a right to payment under the Social Security Act commits a crime punishable under Federal law and/or State law. I affirm that all information I have given in this document is true.

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 address.

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)*

Integrity Representative Payee Services, Inc.

Application

Full Name_____ Date_____

Address_____

Phone (1)_____ (2)_____

DOB_____SS#_____ Marital Status_____

Income
Source(s)_____

Source #1

Address_____

Contact for this source:

Name_____ Phone_____Position_____

Source #2 (if applicable)

Address_____

Contact for this source:

Name_____ Phone_____Position_____

Secondary/Emergency Contact Information

1.) Name_____ Relationship_____

Address_____

Phone (1)_____ (2)_____

2.) Name_____ Relationship_____

Address_____

Phone (1)_____ (2)_____

_____ _____

Client Signature/Date Witness Signature/Date

Integrity Representative Payee Services, Inc.

Guardian/Living Arrangements Form

Client's Name: _____

Referred By (Please list your name and contact information):

_____

1.) Does this client have a legal guardian? Circle YES or NO. If yes, please list their name, address and phone number here

_____

_____

Does this client live alone, with roommates, or in a public facility? If they have roommates, please list the names of everyone they live with and the client's relationship with each person. If the client lives alone or in a public facility, just indicate that on this form

Integrity Representative Payee Services, Inc.

Client Authorization

By signing this document, the client agrees to the following:

I have applied to have Integrity Representative Payee Services, Inc. (mentioned hereafter as "IRPS") receive my income on my behalf and manage my bill payment.

I understand the nature of this relationship involves IRPS opening and/or having access to one or multiple bank accounts in my name. The account(s) will take in deposits, and IRPS will disburse checks to pay my bills through the funds in said account(s). IRPS may transfer funds from said account to another account in my name if applicable.

I authorize any employer, creditor, bank, case manager, or social worker to release my information, both verbal and written, to IRPS and its representatives.

I authorize any employer, creditor, bank, case manager, or social worker to allow IRPS to change contact and address information as they deem necessary.

I authorize IRPS to release information they deem necessary or helpful to any employer, creditor, bank, case manager, or social worker.

A copy of this authorization may be accepted as an original.

_____ _____

Client Signature/Date Witness Signature/Date

Integrity Representative Payee Services, Inc.

Agreement and Terms

I agree to utilize Integrity Representative Payee Services, Inc. (mentioned hereafter as "IRPS") to receive my income and pay my bills.

IRPS will create a new bank account in which my income and expenses will be managed.

I agree to make regular deposits from my current income source(s), which are listed on the application.

IRPS will disburse funds from this account to pay the creditors designated on the list of creditors document. IRPS will also pay new creditors I inform them of, and issue checks directly to me, based on an agreed upon budget.

I will arrange for my creditors to send invoices directly to IRPS for payment. If I choose to continue to have creditor invoices mailed directly to me, I will tell IRPS how much is owed to the creditor as soon as I receive the invoice.

I understand that my creditors and bank account records will remain on file with IRPS for a period of up to 24 months.

I agree to pay IRPS a monthly fee of $_____ for this service, which will be disbursed from the bank account IRPS uses to manage my income and expenses. This monthly fee is subject to increase on an annual basis.

_____ _____

Client Signature/Date Witness Signature/Date

Integrity Representative Payee Services, Inc.

Creditors to be paid:

Creditor Name Creditor Address	Account Number Creditor Phone Number	Due Date Estimated Monthly Payment
Creditor Name Creditor Address	Account Number Creditor Phone Number	Due Date Estimated Monthly Payment
Creditor Name Creditor Address	Account Number Creditor Phone Number	Due Date Estimated Monthly Payment
Creditor Name Creditor Address	Account Number Creditor Phone Number	Due Date Estimated Monthly Payment
Creditor Name Creditor Address	Account Number Creditor Phone Number	Due Date Estimated Monthly Payment
Creditor Name Creditor Address	Account Number Creditor Phone Number	Due Date Estimated Monthly Payment

* if there are more Creditors, please include on a copy of this form

** you may also include copies of bills along with this form

ID Card Information

State Issued _____

Driver's License or State ID _____

Number _____

Issue Date _____

Expiration Date _____

Please copy this latest facility payee packet and use whenever you are applying to be payee for someone. Old versions of the payee application do not include all the questions needed to update our records and SSA follow up may be needed. **To prevent delays, we need all of these forms returned at the same time.** The packet includes:

1. **Payee application** (SSA-11, 08-2009)
2. **Capability statement** (SSA-787) – If the individual had a previous payee before coming to your facility, we do not need this form as capability has already been established.
3. **Advance Notification** (SSA-4164)- If the individual cannot sign their name, have them mark an "X" and have two people witness the signature. If the individual cannot mark with an "X", then do not complete the form as SSA will be required to send an advance notice to the individual whether they understand it or not.
4. **SSI form** - To be completed only if an individual receives SSI. If you are not sure which benefit they receive, complete it and return with documents mentioned above.
5. If there is a **legal guardian**, we will need the original court documents. These will be returned to you. There is no need for a capability statement from a doctor if the beneficiary has a legal guardian.

SOCIAL SECURITY ADMINISTRATION — TOE 250 — Form Approved OMB No. 0960-0014

REQUEST TO BE SELECTED AS PAYEE	FOR SSA USE ONLY								FOR SSA USE ONLY
	Name of Bene. Sym.	Program	Date of Birth	Type	Gdn.	Cus.	Inst.	Nam.	
									DISTRICT OFFICE CODE
PRINT IN INK:									STATE AND COUNTY CODE:

The name of the NUMBER HOLDER	SOCIAL SECURITY NUMBER

The name of the PERSON(S) (if different from above) for whom you are filing (the "claimant(s)")	SOCIAL SECURITY NUMBER(S)

Answer item 1 ONLY if you are the claimant and want your benefits paid directly to you.

1. I request that I be paid directly.

   CHECK HERE ☐ and answer only items 3, 5, 6, and 8 before signing the form on page 4.

I REQUEST THAT THE SOCIAL SECURITY, SUPPLEMENTAL SECURITY INCOME, OR SPECIAL VETERANS BENEFITS FOR THE CLAIMANT(S) NAMED ABOVE BE PAID TO ME AS REPRESENTATIVE PAYEE.

2. Explain why you think the claimant is not able to handle his/her own benefits.
   (In your answer, describe how he/she manages any money he/she receives now.)

   ☐ Claimant is a minor child.

3. Explain why you would be the best representative payee. (Use Remarks if you need more space.)

4. If you are appointed payee, how will you know about the claimant's needs?

   ☐ Live with me or in the institution I represent.
   ☐ Daily visits.
   ☐ Visits at least once a week.
   ☐ By other means. Explain:

5. Does the claimant have a court-appointed legal guardian/conservator? ☐ YES ☐ NO

   IF YES, enter the legal guardian/conservator's:

   NAME _____

   ADDRESS _____

   PHONE NUMBER _____

   TITLE _____

   DATE OF APPOINTMENT _____

   Explain the circumstances of the appointment. (Use remarks if you need more space.)

6. (a) Where does the claimant live?

- ☐ Alone
- ☐ In my home (Go to (b).)
- ☐ With a relative (Go to (b).)
- ☐ With someone else (Go to (b).)
- ☐ In a board and care facility (Go to (b).)
- ☐ In a public institution (Go to (c).)
- ☐ In a private institution (Go to (c).)
- ☐ In a nursing home (Go to (c).)
- ☐ In the institution I represent (Go to (c).)

(b) Enter the names and relationships of any other people who live with the claimant.

NAME	RELATIONSHIP

(c) Enter the claimant's residence and mailing addresses (if different from yours).

Residence: Mailing: Telephone Number:

(d) Do you expect the claimant's living arrangements to change in the next year?

☐ YES ☐ NO If YES, explain what changes are expected and when they will occur. (Use Remarks if you need more space.)

7. If you are applying on behalf of minor child(ren) and you are not the parent,

Does the child(ren) have a living natural or adoptive parent? ☐ YES ☐ NO

If YES, enter: (a) Name of parent

(b) Address of parent

(c) Telephone number

(d) Does the parent show interest in the child? ☐ YES ☐ NO

Please explain.

8. List the names and relationship of any (other) relatives or close friends who have provided support and/or show active interest with the claimant. Describe the type and amount of support and/or how interest is displayed.

NAME	ADDRESS/PHONE NO.	RELATIONSHIP	DESCRIBE

9. Check the block that describes your relationship to the claimant.

(a) ☐ Official of bank, agency or institution with responsibility for the person. Enter below which you represent:

- ☐ Bank
- ☐ Social Agency
- ☐ Public Official
- ☐ Institution:
  - ☐ Federal
  - ☐ State/Local
  - ☐ Private non-profit
  - ☐ Private proprietary institution. Is the institution licensed under State law? ☐ YES ☐ NO

IF (a) ABOVE CHECKED, COMPLETE ONLY QUESTIONS 10 AND 11 AND SIGN THE FORM ON PAGE 4.

(b) ☐ Parent

(c) ☐ Spouse

(d) ☐ Other Relative - Specify

(e) ☐ Legal Representative

(f) ☐ Board and Care Home Operator

(g) ☐ Other Individual - Specify

IF (b), (c), (d), or (e) ABOVE CHECKED, GO ON TO QUESTION 12

10. Does the claimant owe you/your organization any money now or will he/she owe you money in the future? ☐ YES ☐ NO

If YES, enter the amount he/she owes you/your organization, the date(s) was/will be incurred and describe why the debt was/will be incurred.

INFORMATION ABOUT INSTITUTIONS, AGENCIES AND BANKS APPLYING TO BE

11. (a) Enter the name of the institution NEW RIVER VALLEY COMMUNTIY SERVICES

(b) Enter the EIN of the institution EIN # 54-0903278

INFORMATION ABOUT INDIVIDUALS APPLYING TO BE REPRESENTATIVE PAYEE

12. Enter: YOUR NAME _____

DATE OF BIRTH _____

SOCIAL SECURITY NUMBER _____

ANY OTHER NAME YOU HAVE USED _____

OTHER SSN'S YOU HAVE USED _____

13. How long have you known the claimant? _____

14. If the claimant lives with you, who takes care of the claimant when work or other activity takes you away from home?

What is his/her relationship to the claimant?

15. (a) Main source of your income

- ☐ Employed (answer (b) below)
- ☐ Self-employed (Type of Business _____)
- ☐ Social Security benefits (Claim Number _____)
- ☐ Pension (describe _____)
- ☐ Supplemental Security Income payments (Claim Number _____)
- ☐ AFDC (County & State _____)
- ☐ Other Welfare (describe _____)
- ☐ Other (describe _____)

(b) Enter your employer's name and address:

How long have you been employed by this employer? _____

(If less than 1 year, enter name and address of previous employer in Remarks.)

16. (a) Have you ever been convicted of a felony? ☐ YES ☐ NO

If YES: What was the crime? _____

On what date were you convicted? _____

What was your sentence? _____

If imprisoned, when were you released? _____

If probation was ordered, when did/will your probation end? _____

(b) Have you ever been convicted of any offense under federal or state law which resulted in imprisonment for more than one year? ☐ YES ☐ NO

If YES:What was the crime? _____

On what date were you convicted? _____

What was your sentence? _____

If imprisoned, when were you released? _____

If probation was ordered, when did/will your probation end? _____

17. Do you have any unsatisfied FELONY warrants (or in jurisdictions that do not define crimes as felonies, a crime punishable by death or imprisonment exceeding 1 year) for your arrest? YES ☐ NO ☐

If YES: Date of Warrant _____
State where warrant was issued _____

18. How long have you lived at your current address? (Give Date MM/YY)

_____

REMARKS: *(This space may be used for explaining any answers to the questions. If you need more space, attach a separate sheet.)*

PLEASE READ THE FOLLOWING INFORMATION CAREFULLY BEFORE SIGNING THIS FORM

I/my organization:

- Must use all payments made to me/my organization as the representative payee for the claimant's current needs or (if not currently needed) save them for his/her future needs.
- May be held liable for repayment if I/my organization misuse the payments or if I/my organization am/is at fault for any overpayment of benefits.
- May be punished under Federal law by fine, imprisonment or both if I/my organization am/is found guilty of misuse of Social Security or SSI benefits.

I/my organization will:

- Use the payments for the claimant's current needs and save any currently unneeded benefits for future use.
- File an accounting report on how the payments were used, and make all supporting records available for review if requested by the Social Security Administration.
- Reimburse the amount of any loss suffered by any claimant due to misuse of Social Security or SSI funds by me/my organization.
- Notify the Social Security Administration when the claimant dies, leaves my/my organization's custody or otherwise changes his/her living arrangements or he/she is no longer my/my organization's responsibility.
- Comply with the conditions for reporting certain events (listed on the attached sheets(s) which I/my organization will keep for my/my organization's records) and for returning checks the claimant is not due.
- File an annual report of earnings if required.
- Notify the Social Security Administration as soon as I/my organization can no longer act as representative payee or the claimant no longer needs a payee.

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.

SIGNATURE OF APPLICANT	DATE *(Month, day, year)*
Signature *(First name, middle initial, last name) (Write in ink)*	Telephone number(s) at which you may be contacted during the day
SIGN HERE ▷	

Print Your Name & Title *(If a representative or employee of an institution/organization)*

Mailing Address *(Number and street, Apt. No., P.O. Box, or Rural Route)*

City and State	Zip Code	Name of County

Residence Address *(Number and street, Apt. No., P.O. Box, or Rural Route)*

City and State	Zip Code	Name of County

Witnesses are only required if this application has been signed by mark (X) above. If signed by mark (X), two witnesses to the signing who know the applicant making the request 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)*

SOCIAL SECURITY ADMINISTRATION | TOE 250 | Form Approved OMB No.0960-0024

PHYSICIAN'S/MEDICAL OFFICER'S STATEMENT OF PATIENT'S CAPABILITY TO MANAGE BENEFITS

PAPERWORK REDUCTION ACT:

This information collection meets the clearance requirements of 44 U.S.C. §3507, as amended by Section 2 of the Paperwork Reduction Act of 1995. You are not required to answer these questions unless we display a valid Office of Management and Budget control number. We estimate that it will take you about 10 minutes to read the instructions, gather the necessary facts, and answer the questions.

n

Privacy Act: This report is authorized by sections 205(a) and 205(j) of the Social Security Act, as amended (42 U.S.C. 405(a) and 405(j). While you are not required to respond, your cooperation will help us decide whether any Social Security benefits that may be due should be paid directly to the patient or to someone else on the patient's behalf. Your cooperation in completing and returning this statement will be appreciated.

We may also use the information you give us when we match records by computer. Matching programs compare our records with those of other Federal, State, or local government agencies. Many agencies may use matching programs to find or prove that a person qualifies for benefits paid by the Federal government. The law allows us to do this even if you do not agree to it. Explanations about these and other reasons why information you provide may be used or given out are available in Social Security Offices. If you want to learn more about this, contact any Social Security Office.

In replying, use this address:
SOCIAL SECURITY ADMINISTRATION

TELEPHONE NUMBER (Include Area Code)
( )

DATE

SSA CONTACT

IDENTIFYING INFORMATION (SSA Only)
If different from patient

NAME OF WAGE EARNER OR SELF-EMPLOYED PERSON

SOCIAL SECURITY NUMBER
___ ___ ___ / ___ ___ / ___ ___ ___ ___

PATIENT'S NAME

PATIENT'S ADDRESS (Number and Street, City, State, and ZIP Code)

PATIENT'S SOCIAL SECURITY NUMBER
___ ___ ___ / ___ ___ / ___ ___ ___ ___

PATIENT'S DATE OF BIRTH

YOUR HELP IS NEEDED

The patient shown above has filed for or is receiving Social Security or Supplemental Security Income payments. We need you to complete the back of this form and return it to us in the enclosed envelope to help us decide if we should pay this person directly or if he or she needs a representative payee to handle the funds. Please Note: This determination affects how benefits are paid and has no bearing on disability determinations. Thank you for your help.

WHO IS A REPRESENTATIVE PAYEE

A representative payee is someone who manages the patient's money to make sure the patient's needs are met. The payee has a strong and continuing interest in the patient's well-being and is usually a family member or close friend.

WHO NEEDS A REPRESENTATIVE PAYEE

Some individuals age 18 and older who have mental or physical impairments are not capable of handling their funds or directing others how to handle them to meet their basic needs, so we select a representative payee to receive their payments. Examples of impairments which may cause incapability are senility, severe brain damage or chronic schizophrenia. However, even though a person may need some assistance with such things as bill paying, etc., does not necessarily mean he/she cannot make decisions concerning basic needs and is incapable of managing his/her own money.

PLEASE COMPLETE THE INFORMATION ON THE REVERSE OF THIS FORM

1. Date you last examined the patient _____

2. Do you believe the patient is capable of managing or directing the management of benefits in his or her own best interest?

By capable we mean that the patient:

- o Is able to understand and act on the ordinary affairs of life, such as providing for own adequate food, housing, clothing, etc., and
- o Is able, in spite of physical impairments, to manage funds or direct others how to manage them.

☐ Yes	☐ No	☐ Unsure
If "Yes", please omit question 3, but be sure to sign and date the form.	If "No", please provide a brief summary of the findings that led to this conclusion. Also, complete question 3.	If "unsure", please explain.

3. Do you expect the patient to be able to manage funds in the future (for example, the patient is temporarily unconscious)?

☐ Yes ☐ No

If yes, please explain.

NAME OF PHYSICIAN/MEDICAL OFFICER *(Please print.)*	TITLE
ADDRESS *(Number and street, City, State, and ZIP Code)*	TELEPHONE NUMBER *(Include Area Code)* ( )

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 PHYSICIAN/MEDICAL OFFICER	DATE

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)

RECORD OF INSTITUTIONALIZATION

This must be completed if SSI is involved.

Name of Applicant/Recipient: _____

SSN: _____

Name of Facility: _____

Address: _____

Telephone: _____

Type of Facility: Public or Private and Penal Educational Medicaid Certified

Date Admitted: _____

Expected/Actual Date of Release: _____

Admitted from another institution: Yes or No

Which Institution: _____

Is Medicaid paying 50% of the cost of care? Yes or No

If yes, **starting with what date?** _____

If no, who is paying? _____

Name of Source: _____

Title or Office: _____

Signature: _____

Abbreviated 8045/rhe

Client Name: _____

DOB: / / - Mother's Maiden Name: _____ - State Born In: _____

SS#: Next of Kin:

CONSENT TO ACT AS MY REPRESENTATIVE PAYEE

I, _____ do hereby authorize New River Valley
Client, Legal Guardian, or Authorized Representative

Community Services (NRVCS) to act as my Representative Payee. I understand that a NRVCS staff will be assigned to assist me in managing my Social Security and/or SSI payments according to the guidelines set forth by Social Security.

I/We agree to the following conditions:

1. The staff of NRVCS shall follow the prescribed guidelines as set forth by Social Security. The staff shall further be guided by the Policies and Procedures set forth in the Management of Client Funds section of the Accounting Policies and Procedures.

2. The client agrees to report all available funds to the designated staff of NRVCS. Any non-reported funds are not the responsibility of NRVCS.

3. The client agrees to request expenditures consistent with his/her established budget. Abusive or threatening behavior by the client regarding his/her funds is not acceptable and may result in the termination of this agreement.

4. The client or NRVCS reserves the right to terminate this agreement upon a written thirty (30) day notice.

5. The client agrees to allow Payee Specialist to contact Vendors on their behalf.

6. I understand that NRVCS shall charge a fee for this service according to my monthly Social Security/SSI income with exception of Clients who receive auxiliary grant funds. The monthly fee shall be calculated according to the following:

Monthly Income	Payee Fee
Below $500	$15.00
$500-$750	$33.00
Above $750	$41.00

_____ _____
Client, Guardian or Legal Representative Signature Date

_____ _____
Designated NRVCS Staff Signature Date

_____ _____
Supervisor of Designated NRVCS Staff Date

Witnesses are required ONLY if this Consent Form has been signed by mark (X) above. If signed by mark (X), two witnesses to the signing who know the Client must sign below giving their full addresses.

NEW RIVER VALLEY COMMUNITY SERVICES

REPRESENTATIVE PAYEE MONTHLY BUDGET AGREEMENT

PAYEE USE ONLY LOC:

V:

RU:

CLIENT ID:

CLIENT SS#

DATE OF BIRTH

PLACE OF BIRTH

MOTHER'S MAIDEN NAME

Next of Kin

NAME:

ADDRESS:

ORIGINAL DATE: 1/1/2016

☐ BUDGET UPDATE

**

**

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**

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**REVISED DATES MUST BE THE 1ST ONLY

EXPENSE/REVENUE CATEGORY	MONTHLY AMOUNT	VENDOR	FREQUENCY IF NOT MONTHLY	NOTES/SPECIAL INSTRUCTIONS
SOCIAL SECURITY				
SSDI				
EMPLOYMENT INCOME				
VA COMP				
RAILROAD RETIREMENT				
INTEREST INCOME				
MISC.				
TOTAL REVENUE	0.00			
HOUSING:				
RENT				
MORTGAGE				
RESIDENTIAL FEE:				
FREESTONE				
ELMTREE				
UTILITIES:				
ELECTRIC				
GAS				
WATER/SEWER				
GARBAGE				
CABLE				
TELEPHONE/CELLPHONE				
GROCERIES			WEEKLY AMOUNT:	____per wk; 5th week (circle one) Yes No
MEDICAL AND DENTAL:				
OUTSIDE MEDICAL/DENTAL BILLS				
MEDICATIONS				
MEDICAID WAIVER PATIENT PAY				
NRVCS SERVICES SELF PAY				
NRVCS PAYEE FEE				

CLIENT ID:
CLIENT SS#
DATE OF BIRTH
PLACE OF BIRTH
MOTHER'S MAIDEN NAME
Next of Kin
NAME:
ADDRESS:

ORIGINAL DATE: 1/1/2016

☐ BUDGET UPDATE

RU:

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**REVISED DATES MUST BE THE 1ST ONLY

EXPENSE/REVENUE CATEGORY	MONTHLY AMOUNT	VENDOR	FREQUENCY IF NOT MONTHLY	NOTES/SPECIAL INSTRUCTIONS
INSURANCE:				
HEALTH				
HOMEOWNERS				
AUTO				
LIFE				
BURIAL				
LOAN PAYMENTS:				
AUTO				
OTHER (Please specify)				
SPENDING MONEY				
LAUNDRY				
HOUSEHOLD/CLOTHING				
SPENDING MONEY				
CIGARETTES(if paid to outside vendor)			WEEKLY AMOUNT:	per wk; 5th week(circle one) Yes No
MISCELLANEOUS EXPENSE				
COURT FINES				
TOTAL EXPENSES	0.00			
BALANCE	**0.00**			

I acknowledge that I, my Legal Guardian or my Authorized Representative have authorized New River Valley Community Services to be my Representative Payee. As Representative Payee, NRVCS shall manage my funds in a manner that will ensure that my basic needs are met, provide me with access to my funds and information regarding my finances and insure that my financial assets are protected. I understand that NRVCS acting as my payee, will write checks to cover the the above expenses. I further understand that other expenses not outlined in this budget may be paid on my behalf if funds are available. The remainder of my funds will be available to me upon my request. My funds may not be used to purchase alcohol, illegal drugs or firearms. This budget agreement must be reviewed with me annually and my signature indicates agreement. I understand that my budget will be updated when income or expenditures change and I will be informed when revisions are made.

Client signature _____ Date _____ NRVCS Staff Signature _____

Legal Authorized Representative or Guardian _____ Date _____ Print Staff Signature _____

Revised 11/16/15

So you've chosen to work with a Bookkeeper.....

Clients decide to work with a Bookkeeper for a number of reasons, such as:

- Securing housing
- Participating in a program that suggests or requires bookkeeping
- Wanting or needing assistance with payment of income and expenses

Every bookkeeping client will receive the following benefits:

- Budget management
- Financial education (as requested by the client)
- Peace of mind, knowing their funds are with a company in an established account

It is important that you are aware of these specifics when working with a Bookkeeper:

- We are providing you a service for a fee. The fee for 2015 is $41.00 per month. This is subject to change on an annual basis.
- You have the right to start, stop, or change service at any time. We just need you to make any changes in writing.
- You have the right to know your balance at any time. If you ask for your balance at the bank, that balance won't include any uncashed checks that have been sent to you or your creditors. So, it is better to request your balance from us since we have accounted for every check as if it was already cashed.
- If we are managing benefits you receive from the Social Security Administration, you have access to your account at the bank. We encourage you to stick with the budget we have created with you. However, if you want or need more money, please request it from us so we can send you a check.

We are excited to help you with this part of your life. We will make every effort to provide you with friendly, helpful, and responsive service!

Client Signature/Date

Witness Signature/Date

Integrity Representative Payee Services, Inc.

Application

Full Name_____ Date_____

Address_____

Phone (1)_____ (2)_____

DOB_____SS#_____ Marital Status_____

Income
Source(s)_____

Source #1

Address_____

Contact for this source:

Name_____ Phone_____Position_____

Source #2 (if applicable)

Address_____

Contact for this source:

Name_____ Phone_____Position_____

Secondary/Emergency Contact Information

1.) Name_____ Relationship_____

Address_____

Phone (1)_____ (2)_____

2.) Name_____ Relationship_____

Address_____

Phone (1)_____ (2)_____

_____ _____
Client Signature/Date Witness Signature/Date

Integrity Representative Payee Services, Inc.

Agreement and Terms

I agree to utilize Integrity Representative Payee Services, Inc. (mentioned hereafter as "IRPS") to receive my income and pay my bills.

IRPS will create a new bank account in which my income and expenses will be managed.

I agree to make regular deposits from my current income source(s), which are listed on the application.

IRPS will disburse funds from this account to pay the creditors designated on the list of creditors document. IRPS will also pay new creditors I inform them of, and issue checks directly to me, based on an agreed upon budget.

I will arrange for my creditors to send invoices directly to IRPS for payment. If I choose to continue to have creditor invoices mailed directly to me, I will tell IRPS how much is owed to the creditor as soon as I receive the invoice.

I understand that my creditors and bank account records will remain on file with IRPS for a period of up to 24 months.

I agree to pay IRPS a monthly fee of $_____ for this service, which will be disbursed from the bank account IRPS uses to manage my income and expenses. This monthly fee is subject to increase on an annual basis.

_____ _____

Client Signature/Date Witness Signature/Date

Integrity Representative Payee Services, Inc.

Client Authorization

By signing this document, the client agrees to the following:

I have applied to have Integrity Representative Payee Services, Inc. (mentioned hereafter as "IRPS") receive my income on my behalf and manage my bill payment.

I understand the nature of this relationship involves IRPS opening and/or having access to one or multiple bank accounts in my name. The account(s) will take in deposits, and IRPS will disburse checks to pay my bills through the funds in said account(s). IRPS may transfer funds from said account to another account in my name if applicable.

I authorize any employer, creditor, bank, case manager, or social worker to release my information, both verbal and written, to IRPS and its representatives.

I authorize any employer, creditor, bank, case manager, or social worker to allow IRPS to change contact and address information as they deem necessary.

I authorize IRPS to release information they deem necessary or helpful to any employer, creditor, bank, case manager, or social worker.

A copy of this authorization may be accepted as an original.

_____ _____

Client Signature/Date Witness Signature/Date

Integrity Representative Payee Services, Inc.

Creditors to be paid:

Creditor Name	Account Number	Due Date
Creditor Address	Creditor Phone Number	Estimated Monthly Payment
Creditor Name	Account Number	Due Date
Creditor Address	Creditor Phone Number	Estimated Monthly Payment
Creditor Name	Account Number	Due Date
Creditor Address	Creditor Phone Number	Estimated Monthly Payment
Creditor Name	Account Number	Due Date
Creditor Address	Creditor Phone Number	Estimated Monthly Payment
Creditor Name	Account Number	Due Date
Creditor Address	Creditor Phone Number	Estimated Monthly Payment
Creditor Name	Account Number	Due Date
Creditor Address	Creditor Phone Number	Estimated Monthly Payment

* if there are more Creditors, please include on a copy of this form

** you may also include copies of bills along with this form

ID Card Information

State Issued _____

Driver's License or State ID _____

Number _____

Issue Date _____

Expiration Date _____