Shascade COMMUNITY SERVICES INC.
1920B California Street · Redding, CA 96001· P: 530-243-1653 · F: 530-245-9295

REPRESENTATIVE PAYEE
FINANCIAL MANAGEMENT AGREEMENT

I, _____, here by enter into this *Agreement* with Shascade Personal Finance Services for the purpose of managing my finances as Representative Payee for my Social Security and/or SSI benefits. I have read (or had read to me) this *Agreement* and agree to the following terms and conditions:

1. My assigned Payee will work with me to manage my funds and assist me in dealing with landlords, creditors, and other vendors.
2. My Payee will disburse my funds following Social Security regulations and our agreed upon budget, paying **basic needs** (shelter, utilities, and food) **first**, and other items second, as agreed upon in advance in my personal budget. All funds will be disbursed by Shascade in check form, **not cash**.
3. You, the client, have the right to receive a copy of your account register, upon your request, at any time.
4. I understand that Shascade PFS must maintain a safe and courteous office, and that to ensure such an environment, **no violence, threats of violence, intoxication, drugs, alcohol, or profane language will be permitted** in the office at any time. I understand that if these standards are violated, Shascade may **return my funds to Social Security and refuse to serve further as my Payee.**
5. I agree to report promptly to my Payee any **change of address, living arrangements, or income** (as required by Social Security regulation). Any changes that are effective on the 1st must be reported by the 25th of the preceding month at the latest!
6. I understand that the hours for **walk-in services are Tuesday and Thursday, 9:00 am to 12:00 pm, 1:00 pm to 3:00 pm.** Phone messages can be left 24 hours a day, 7 days a week.
7. I understand that **"extra money"** (beyond my normal monthly budget) must be requested at least **24 hours in advance** and is subject to approval by my Payee.
8. I realize that Shascade PFS will account to Social Security Administration (SSA) for the uses of my benefits and will report to SSA changes that affect my benefits (incarceration, moves, changes in living arrangements, marital status, income, etc.). I understand that PFS will return to SSA all funds to which I am not entitled.
9. I also understand that **any failure to abide by the terms** of this *Agreement* may result in the termination of the *Agreement* and the return of my funds to the Social Security Administration. I will then have to **find a new payee for my benefits**.
10. Lastly, I agree to the monthly Payee fee of **$41.00** for these services, as approved by the Social Security Administration to be disbursed from my account. This fee is subject to change in response to Social Security regulations.

Consumer Signature *Date* *Payee Signature* *Date*

_____ _____

CLIENT INFORMATION SHEET

TODAY'S DATE: _____

NAME: _____

SOCIAL SECURITY #: _____ DOB: _____

PHYSICAL ADDRESS: _____

CITY : _____ ST: _____ ZIP: _____

MAILING ADDRESS: _____

CITY: _____ ST: _____ ZIP: _____

TEMPORARY: _____ MOVING: _____ WHEN: _____

PHONE: _____ CELL: _____ MESSAGE: _____

OTHER INCOME (TYPE & AMOUNT): _____

CURRENT REP PAYEE: _____ SOC SEC CLAIMS REP: _____

LANDLORD NAME: _____ PHONE: _____ AMOUNT: $_____

ADDRESS: _____

CITY, STATE, ZIP: _____ INCLUDE FOOD & UTILTIES: __YES __NO

OTHER BILLS:

TELEPHONE: _____ ELECTRIC: _____ GAS: _____

COURT FINES: _____ CABLE/SATELLITE: _____ STORAGE UNITS: _____

CAR PAYMENT: _____ CAR INSURANCE: _____ MISC. EXPENSES: _____

OTHER:

_____

_____

_____

_____

SHASCADE COMMUNITY SERVICES (SCS), INC.
PERSONAL FINANCE SERVICES
1920 CALIFORNIA ST., SUITE B
REDDING, CA 96001
P: 530-243-1653 F: 530-245-9295

CONSENT TO RELEASE INFORMATION

This release of information is provided pursuant to California Welfare and Institutions Code, Section 4514 et seq., and California Civil Code, Section 56 et seq.

I, _____, hereby authorize SCS, its agent and employees, to release to and/or exchange the following information/records with _____.

This authorization shall be valid one year from the date signed or until the client leaves SCS unless revoked in writing. This information shall be utilized only for the purpose of:

X Development of Individual Program Plans X Employment Purposes

X Other (specify): Financial Planning X Referral of Services

Signed: _____ Date: _____

NOTICE TO PROVIDERS OF INFORMATION:

All information you supply to SCS is subject to Section 4514, Welfare & Institutions Code, Confidentiality and Disclosure. Regulations allow for inspection of all records by the client, his/her parent/guardian or conservator.

NOTICE TO RECEIVER OF INFORMATION:

The information being released to you is confidential and subject to Section 4514, Welfare and Institution Code. You are prohibited from making any further disclosure of this information without the informed, written consent of the person to whom this information pertains and his/her parent/guardian or conservator.

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

REQUEST TO BE SELECTED AS PAYEE

PRINT IN INK:

FOR SSA USE ONLY							
Name or Bene. Sym.	Program	Date of Birth	Type	Gdn.	Cus.	Inst.	Nam.

FOR SSA USE ONLY

DISTRICT OFFICE CODE

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.)

   HAS EXHIBITED A NEED FOR A PAYEE

   ☐ Claimant is a minor child.

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

   WE ARE A COMMUNITY BASED AGENCY. WE ARE AN AUTHORIZED ORGANIZATION WITH SOCIAL SECURITY APPROVAL AND CAN ASSIST INDIVIDUALS IN OUR COMMUNITY.

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: TELEPHONE OR IN PERSON CONTACTS

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.) UNKNOWN AT THIS TIME.

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 SUPPORT/INTEREST

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

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 __SHASCADE COMMUNITY SERVICES, INC_____ 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 (5-2005)
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