Financial Advocates of Southeast Idaho, Inc.

Payee Request for Social Security

CLIENT DEMOGRAPHIC INFORMATION

Full Name: _____ Date of Birth: _____

Phone Number: _____ Social Security Number: _____

Place of Birth: _____

Current Address: _____ How Long at this address: _____

Previous Address: _____

Mother's Full Name: _____ Mother's Maiden Name: _____

Father's Full Name: _____

Diagnosis: _____

Do You Receive SSI or SSD?: SSI / SSD What is the Amount you Receive?: $ _____

Name of Landlord: _____ Landlord Phone Number: _____

Names and Ages of Any Other People Living in the Same Household: _____

_____

_____

CLIENT HISTORY

Do You Have a Case Worker?: YES / NO If Yes, Fill Out Case Worker Information Below.

Name: _____ Phone #: _____

Agency: _____

Do You Have a Previous/Current Payee?: YES / NO If Yes, Fill Out Payee Information Below.

Name: _____ Phone #: _____

Address: _____

Do You Have a Guardian? YES / NO If Yes, Fill Out Guardian Information Below.

Name: _____ Phone #: _____

Address: _____

If Yes, Have You Submitted the Guardianship Paperwork?: YES / NO / NA

Do You Have A Primary Doctor?: YES / NO If Yes, Fill Out Doctor Information Below.

Name: _____ Phone #: _____

Clinic / Hospital: _____

Have You Submitted the Physician's Release Form?: YES / NO

ADDITIONAL INFORMATION

Why are you asking for a Payee? Please include any relevant information you think we may need. (Use back if needed.): _____

_____

_____

_____

_____

FASI Client Budget & Information

REQUIRED

1. Current physical address:
2. Rent Amount:
3. Who do we write mail check to (landlord):
4. Where do we mail rent check (or is there a way to pay online):
5. Does the client have any other monthly bill, such as medical, pharmacy, phone, internet, utilities (please list name of bill, account number, and address- copy of bill also works):

6. Does client have any other monthly expenses, such as cigarettes, activity fees, gym membership:

7. Does client have any fees/fines, such as Access Corrections, or Court fees:

OPTIONAL *(please answer if known):*

8. Does client have other checking or savings account, besides my fiduciary one?:
9. Does client have assets, such as trusts, bonds, real estate?:
10. Does client have a paid for or paying on a burial plot?:
11. Does client have coin collection, investments, cars?:
12. Does client have food stamps, how much$?:
13. Does client have workers comp or any other paid out compensation?:
14. Is client working? Where? How much do they make?:
15. Has client received any other government assistance?:
16. Is client's rent subsidized? By who? How much?:
17. Does client live alone or have roommates? If they have roommates, does client have their own room or a shared room?:
18. Client's parent's names?:
19. Client's place of birth?:
20. Is client Married?:
21. Has he been in jail or hospital for a month or longer?:
22. Does client get any of the following? Pension? Retirement? Railroad money? Tribal money?:

Whose Records to be Disclosed	
NAME *(First, Middle, Last, Suffix)*	
SSN	Birthday *(MM/DD/YYYY)*

AUTHORIZATION TO DISCLOSE INFORMATION TO THE SOCIAL SECURITY ADMINISTRATION (SSA)

** PLEASE READ THE ENTIRE FORM, BOTH PAGES, BEFORE SIGNING BELOW **

I voluntarily authorize and request disclosure (including paper, oral, and electronic interchange):

OF WHAT ***All my medical records; also education records and other information related to my ability to perform tasks. This includes Specific permission to release:***

1. **All records and other information regarding my treatment, hospitalization, and outpatient care for my impairment(s) including, and not limited to:**
   - Psychological, psychiatric or other mental impairment(s) (excludes "psychotherapy notes" as defined in 45 CFR 164.501)
   - Drug abuse, alcoholism, or other substance abuse
   - Sickle cell anemia
   - Records which may indicate the presence of a communicable or noncommunicable disease; and tests for or records of HIV/AIDS
   - Gene-related impairments (including genetic test results)
2. **Information about how my impairment(s) affects my ability to complete tasks and activities of daily living, and affects my ability to work.**
3. **Copies of educational tests or evaluations, including Individualized Educational Programs, triennial assessments, psychological and speech evaluations, and any other records that can help evaluate function; also teachers' observations and evaluations.**
4. **Information created within 12 months after the date this authorization is signed, as well as past information.**

FROM WHOM

- **All medical sources** (hospitals, clinics, labs, physicians, psychologists, etc.) including mental health, correctional, addiction treatment, and VA health care facilities
- All educational sources (schools, teachers, records administrators, counselors, etc.)
- Social workers/rehabilitation counselors
- Consulting examiners used by SSA
- Employers, insurance companies, workers' compensation programs
- Others who may know about my condition (family, neighbors, friends, public officials)

THIS BOX TO BE COMPLETED BY SSA/DDS (as needed). Additional information to identify the subject (e.g., other names used), the specific source, or the material to be disclosed:

TO WHOM **The Social Security Administration and to the State agency authorized to process my case** (usually called "disability determination services"), **including contract copy services, and doctors or other professionals consulted during the process.** [Also, for international claims, to the U.S. Department of State Foreign Service Post.]

PURPOSE Determining my **eligibility for benefits**, including looking at the combined effect of any impairments that by themselves would not meet SSA's definition of disability; and whether I can manage such benefits.

☐ Determining whether I am **capable of managing benefits ONLY** (check only if this applies)

EXPIRES WHEN This authorization is good for 12 months from the date signed (below my signature).

- I authorize the use of a copy (including electronic copy) of this form for the disclosure of the information described above.
- I understand that there are some circumstances in which this information may be redisclosed to other parties (see page 2 for details).
- I may write to SSA and my sources to revoke this authorization at any time (see page 2 for details).
- SSA will give me a copy of this form if I ask; I may ask the source to allow me to inspect or get a copy of material to be disclosed.
- **I have read both pages of this form and agree to the disclosures above from the types of sources listed.**

PLEASE SIGN USING BLUE OR BLACK INK ONLY **INDIVIDUAL authorizing disclosure Signature**	**IF not signed by subject of disclosure, specify basis for authority to sign** ☐ Parent of minor ☐ Guardian ☐ Other personal representative (explain)
	(Parent/guardian/personal representative sign here if two signatures required by State law)

Date Signed	Street Address		
Phone Number (with area code)	City	State	ZIP

WITNESS *I know the person signing this form or am satisfied of this person's identity:*

Signature	**IF** needed, second witness sign here (e.g., if signed with "X" above)
Phone Number (or Address)	Phone Number (or Address)

This general and special authorization to disclose was developed to comply with the provisions regarding disclosure of medical, educational, and other information under P.L. 104-191 ("HIPAA"); 45 CFR parts 160 and 164; 42 U.S. Code section 290dd-2; 42 CFR part 2; 38 U.S. Code section 7332; 38 CFR 1.475; 20 U.S. Code section 1232g ("FERPA"); 34 CFR parts 99 and 300; and State law.

Explanation of Form SSA-827, "Authorization to Disclose Information to the Social Security Administration (SSA)"

We need your written authorization to help get the information required to process your claim, and to determine your capability of managing benefits. Laws and regulations require that sources of personal information have a signed authorization before releasing it to us. Also, laws require specific authorization for the release of information about certain conditions and from educational sources.

You can provide this authorization by signing a form SSA-827. Federal law permits sources with information about you to release that information if you sign a single authorization to release all your information from all your possible sources. We will make copies of it for each source. A covered entity (that is, a source of medical information about you) may not condition treatment, payment, enrollment, or eligibility for benefits on whether you sign this authorization form. A few States, and some individual sources of information, require that the authorization specifically name the source that you authorize to release personal information. In those cases, we may ask you to sign one authorization for each source and we may contact you again if we need you to sign more authorizations.

You have the right to revoke this authorization at any time, except to the extent a source of information has already relied on it to take an action. To revoke, send a written statement to any Social Security Office. If you do, also send a copy directly to any of your sources that you no longer wish to disclose information about you; SSA can tell you if we identified any sources you didn't tell us about. SSA may use information disclosed prior to revocation to decide your claim.

It is SSA's policy to provide service to people with limited English proficiency in their native language or preferred mode of communication consistent with Executive Order 13166 (August 11, 2000) and the Individuals with Disabilities Education Act. SSA makes every reasonable effort to ensure that the information in the SSA-827 is provided to you in your native or preferred language.

Privacy Act Statement
Collection and Use of Personal Information

Sections 205(a), 223(d), and 1631(d) of the Social Security Act, as amended, allow us to collect this information. Furnishing us this information is voluntary. However, failing to provide all or part of the information may prevent us from making an accurate and timely decision on your claim that could result in a denial or loss of benefits.

We will use the information you provide to determine your eligibility or continuing eligibility for benefits, and your ability to manage any benefits that you currently receive.

We may also share your information for the following purposes, called routine uses:

1. To State audit agencies for auditing State supplementation payments and Medicaid eligibility considerations;
2. To third party contacts where necessary to establish or verify information provided by representative payees or payee applicants; and
3. To Federal, State or local agencies for administering cash or non-cash income maintenance or health maintenance programs.

In addition, we may share this information in accordance with the Privacy Act and other Federal laws. For example, where authorized, we may use and disclose this information in computer matching programs, in which our records are compared with other records to establish or verify a person's eligibility for Federal benefit programs and for repayment of incorrect or delinquent debts under these programs.

A list of additional routine uses is available in our Privacy Act System of Records Notices (SORNs) 60-0089, entitled Claims Folders Systems; 60-0090, entitled Master Beneficiary Record; 60-0320, entitled Electronic Disability; and 60-0103, entitled Supplemental Security Income Record and Special Veterans Benefits. Additional information and a full listing of all our SORNs are available on our website at www.socialsecurity.gov/foia/bluebook.

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 10 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 Social Security at 1-800-772-1213 (TTY 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.***

FASI Procedure & Policies

FASI Hours:

Monday – Thursday 9am - 2pm

Check Day (1st and 3rd) 9:30am - 2:30pm

If Check Day (1st or 3rd) is on a Saturday or Sunday:
FASI open Friday 9:30am-2:30pm

FASI will be closed the two days prior to check day (the 1st)

Phone #: 208-523-1024 **Fax #: 208-542-4584**

Check Pick up Policies:

Checks must be picked up by the beneficiary, the beneficiary's guardian, or the worker of the agency the beneficiary receives services from.
The beneficiary's checks can also be mailed to the above.
For anyone else to be allowed to pick up the beneficiary's checks, the above must call the FASI office in advance to approve the new pick up person. That new person must also arrive with a valid ID.
If there is to be a new permanent person allowed to pick up the beneficiary's checks, then the above must fill out and sign a Pick Up Approval form. This person is subject to FASI's approval and can be denied at any time for any reason.

Budget:

The budget will be generated according to rules and guidelines of Social Security Administration. Meaning that all bills and expenses will be acknowledged and paid before any personal spending is dispersed. Personal spending will either be dispersed weekly to ensure money is available throughout the month, or at the beginning of the month. Any personal spending in an amount over $100 requires a receipt. FASI follows all rules and guidelines set forth by the Social Security Administration. The Budget will remain the same once established unless there is a bill change or updated information is given to the payee. FASI will reach out as needed or discussed. For more information please contact your local Social Security office, or go to ssa.gov

Addendums:

Addendums may be requested by the beneficiary, the beneficiary's guardian, or the worker of the agency the beneficiary receives services from, when an additional expense arises. Addendums are subject to Payee approval, and may be denied based on the individual beneficiary's account and expenses.
Addendums are subject to a 24 hour policy. Meaning if an addendum is approved by the Payee, the check will not be ready for pick up or mail until the next business day.

Behavior:

Beneficiary agrees to sign or verbally approve all budgets and or addendums, or approve someone else to do so.
Beneficiary will be polite, civil, and respectful to all FASI staff. Any destructive or abusive behavior may lead to termination by FASI for payee services.
Beneficiary will adhere to their budget throughout the month, receiving spending money only on the day indicated.
If the beneficiary has a worker, that worker will be contacted first before FASI.
FASI may issue individual client behavior plans to those it is deemed necessary. FASI has sole discretion of this.

This document is an agreement set in place to protect both you as a client and FASI as a company. By signing this form you agree to follow all FASI Policies. FASI's Polices are subject to change as needed per company's Director Toni Hunt. Failure to comply with company policies or individual behavior policies may lead to termination by FASI. FASI has the right to withdraw services at any time for any reason.

Beneficiary Signature _____ Date _____

Guardian / Worker Signature _____ Date _____

1675 Curlew Dr, Ammon, ID 83406 - Phone: 208-523-1024

Release of Information Form
This is a consent for release of information (hereinafter referred to as the "release of information"

_____
(Name of Individual)

_____
(Date of Birth)

_____
(Social Security Number)

_____
(Guardian or Power of Attorney)

I authorize Financial Advocates of Southeast Idaho (FASI) to release or obtain the any and all information for the purpose of paying, obtain billing information, and/or changing the billing address for any debts I may owe. I also authorize Financial Advocates of Southeast Idaho (FASI) to release or obtain the any and all information regarding my admittance or discharge into a hospital, institution, or county jail.

I understand I have the right to see this information at any time. I understand that I can revoke this consent in writing to both the person giving and the person receiving the information. Any information already released may be used as stated on the consent. By my signature below, I affirm that I have read this release or it has been read to me, and I understand its content.

_____
Individual's Printed Name or (Power of Attorney/ guardian)

_____
Witness Printed Name

_____
Date

_____
Individual's Signature or (Power of Attorney/ guardian)

_____
Witness Signature

_____
Date