As you have chosen to enter into a fiduciary representative relationship on your own: the goal of working with you as your asset manager is to assist you in learning more about budgeting, bill paying and, in general, managing your funds so that you can become independent. This is what we will work towards with you. If you want to change your asset management, let us know. Because you have voluntarily entered and asked to be released from this contract your records will be provided to you and you must make arrangements with your case worker to move your direct deposit. Your organization will determine if such a change is in your best interest; this will likely include a call to let us know you have requested a change in payee.

We understand that, as an adult, you may not like having a payee. We pledge to provide this service with respect and care. We ask that you, in turn, behave respectfully. Show up at appointments clean and sober. We also ask that you try to talk with us if you feel, at any time, that this service is not going well or you feel dissatisfied. We pledge to do the same.

Please keep in mind that you will have a say in determining your monthly budget. Please let us know about any outstanding bills or unusual expenses so we can work with you to fit them into your budget. Also, please report any changes in expenses as soon as you can after you learn about them. Failure to notify us of changes in employment status or a change in residence may result in loss of benefits. Support Management Solutions, Inc. takes no responsibility for bills which cannot be paid due to loss of benefits.

Our main role as your payee is to make sure that your basic needs are met. This means paying your rent and utilities, as well as costs for food, clothing, transportation, and other basic needs.

Asset Manager Responsibilities

1. The manager must pay your bills for necessities, including rent, utilities, food and transportation.

2. The manager will work with you collaboratively on an amount for personal expenses to be provided from the balance amount once bills are deducted and a monthly budget is established.

3. If you are homeless, 25 percent of your check will be saved each month towards housing. We will make sure that your savings do not exceed the amount allowed by SSA and Medicaid. If there is past rent due and this amount will likely generate a garnishment payment arrangements will be made on your behalf.

4. If you are hospitalized in a state hospital or are incarcerated for at least one full calendar month and you receive SSI, you will not be eligible for SSI during that time. (There is an exception for hospitalization if funds are needed to pay rent; we will discuss this with you). Generally, for those months, the SSI check(s) will be returned to SSA. If you have other funds these funds will be used to maintain your residence or payment for storage.

5. If you receive SSDI and are hospitalized, benefits will continue, and bills will be paid. If you receive SSDI and are incarcerated, benefits continue until you are convicted of a felony. Once a felony conviction occurs, you cannot receive SSDI if you remain incarcerated. Upon release, you will need documentation of legal release for SSA to restart benefits.

Beneficiary Responsibilities

- ❖You understand that your funds must be first used for rent, utilities, food, clothing, and to meet personal needs. . There is a _____ monthly fee for this service.

- ❖If you are arrested, the asset manager will not use SSI to pay for bail. Using the government benefits for alcohol or drugs is not allowed. If you have pension or other disability benefits which are deposited to your account and they will cover your bail then these funds may be used at your request.

- ❖For your protection, any checks will be mailed only to you. If your check must be picked up, the payee will ask you to sign a receipt. Your allowance is paid WEEKLY by check or deposited to a prepaid card..

❖Generally, with SSI, if your benefits are suspended for 12 months or more, you will need to reapply.

❖Keep your address and phone number current. We will attempt to contact you biweekly. In the event that we are unable to contact you two weeks in a row we will stop allowance checks until a face to face visit can be arranged.

❖A reserve will be kept for you and in the event of an emergency these funds can be issued for auto repair to your auto, home repair, and medical events for yourself or a dependent. Checks will **not** be made out to you only to legitimate business once invoices are provided. Please confirm funds availability before committing to a repair. Once the reserve meets the maximum best use of additional funds will be discussed with you.

Name of Beneficiary (printed): _____

Name of Beneficiary (signed): _____

Date:_____/_____/_____

Staff Name (printed): _____

Staff Name (signed): _____

Date:_____/_____/_____

BUDGET POLICY

I understand my budget will be set up based on my funds and bills to be paid by my representative payee counselor. Alterations to this approved budget because of changes in assets or bills will be discussed with me in a timely manner. My budget will be updated yearly as result in Social Security increases and placed in my file. The updated budget will also be sent to me. Any issues that arise pertaining to my budget may be discussed with the representative payee counselor.

FRAUD POLICY

Support Management Solutions, Inc. (the Company) is committed to preventing, identifying, and reporting any fraudulent activity related to the Company's services, activities and administration of grants. Fraud may include but is not limited to false statements provided by or to staff, contractors, clients, beneficiaries and stakeholders. Fraudulent activities may include but are not limited to knowingly misrepresenting income or expenses, assisting or counseling anyone to misrepresent facts or circumstances related to eligibility for programs or benefits, bribery, kickbacks, theft or embezzlement, forgery or alteration of documents, destruction or concealment of records, profiting from insider knowledge, or a conflict of interest. The Company will investigate any reports of fraud. The Company reserves the right to involve law enforcement authorities in its investigation. Any documented fraudulent activity may result in administrative or criminal action being taken against those involved including termination from any program sponsored by the Company or termination from employment by the Company. The Company will not retaliate against any party who reports fraud, criminal activities or other program irregularities. Any suspected fraudulent activity should be reported to the Company's currently appointed Risk Manager with sufficient specificity to facilitate an investigation.

Printed Name of Client : _____

Signature : _____

DATE : _____

CLIENT INFORMATION SHEET

Client Name : _____ Date of Birth : _____

Social Security Number : _____

Mailing Address : _____

***SSA MANDATE: IF HOMELESS/IN HOSPITAL- PROVIDE ADDRESS FOR SSA CONTACT**

Telephone : _____ Cell Phone : _____

Email : _____

Marital Status : _____ # of people in home : _____

City and State of Client's Birth : _____

Maiden Name of Mother : _____

****Name and relationship of all persons living with client**

Referring Agency Name : _____

Agency Address : _____

Case Manager Name : _____
Telephone # Ext : _____

Email : _____

Emergency Contact

Next of Kin/Emergency Contact : _____
Telephone : _____ Mobile Phone : _____

Email : _____

Next of Kin/Emergency Contact's Address : _____

_____

Next of Kin/Emergency Contact's Relationship to Applicant : _____

Do you receive food stamps? Yes No

If Yes, Amount : $_____

Medicaid/Medicare Number : _____

Life Insurance Company : _____

Term Life Insurance (Premium Amount) : _____

Whole-Life Insurance (Premium Amount) : $ _____ Cash Value : $ _____

Any assets (e.g. bank accounts, cars, real estate)? Yes

No

If so, please list them along with the value :

_____
_____
_____
_____
_____
_____
_____
_____

Have you ever been convicted of a felony? Yes No

Printed Name of Client : _____

Signature : _____

DATE : _____

NEW CLIENT GENERAL HOUSEHOLD INFORMATION

To expedite the application process please complete and submit with completed application form. Please list all persons currently living in the household. Please provide an answer to all the questions listed. Please write N/A for any information that does not apply to your situation.

- NAME : _____
- DATE OF BIRTH : _____
- RELATIONSHIP TO CLAIMANT : _____
- SOCIAL SECURITY NUMBER : _____
- NAME : _____
- DATE OF BIRTH : _____
- RELATIONSHIP TO CLAIMANT : _____
- SOCIAL SECURITY NUMBER : _____
- NAME : _____
- DATE OF BIRTH : _____
- RELATIONSHIP TO CLAIMANT : _____
- SOCIAL SECURITY NUMBER :_____
- NAME : _____
- DATE OF BIRTH : _____
- RELATIONSHIP TO CLAIMANT : _____
- SOCIAL SECURITY NUMBER : _____
- NAME : _____
- DATE OF BIRTH : _____
- RELATIONSHIP TO CLAIMANT : _____
- SOCIAL SECURITY NUMBER : _____

AVERAGE MONTHLY EXPENSES

Please tell us approximately how much you spend a month on the following items.

RENT/MORTGAGE : $_____ ELECTRICITY : $_____

WATER : $_____ PHONE : $_____

CABLE : $_____ GAS/FUEL : $_____

FOOD : $_____ HOUSEHOLD ITEMS : $_____

PERSONAL HYGINE : $_____ INSURANCE : $_____

TITHES : $_____ CHILDCARE : $_____

PART III CLIENT/ AGENCY RESPONSIBILTY CHECKLIST

Name : _____ SSN : _____

My signature indicates the following items have been discussed with me to my satisfaction and any questions have been answered. SMS, Inc. (Agency) rules have been explained: Services are made available to clients without regard to race, religion, creed, or origin.

The Agency's expectations of me have been explained:

A client is expected to provide truthful, accurate information to the best of his/his knowledge. The client needs to notify the Agency when changes occur in health, living conditions, or employment and income.

My rights and responsibilities as a client have been explained:

A client has the right to confidential treatment of information provided to any Agency staff member. The client's responsibility is to provide adequate, accurate information so that the agency will provide efficient service to meet client needs.

Hours of service availability have been explained to me:

Agency hours are Monday –Thursday 9:30am-4:30pm. Generally, services are not available after 5:00pm, on weekends, or scheduled holidays***. Conferences are done by appointment only. SMS will visit or meet with a client with an advocate or social service worker or at an agreed upon public location .***

The Grievance procedure to follow when a violation of a client's rights has occurred has been explained.

Stage 1: Within 30 days of incident of complaint, there should be an informal discussion with the service staff directly involved.

Stage 2: Within 14 days of stage 1 A written complaint should be submitted to Family Services, Attention: Director of Financial Management Representative Payee Program. A response from the Program director will be given within 14 working days of complaint.

Stage 3: A formal appeal to SMS addressed to Executive Director must be filed within 14 days of completing stage 2. The Executive Director will give a response within 14 days.

I agree to release any information from Support Management Solutions, Inc. to any agency who is acting in an advocacy role to work for the benefit of my finances. I agree to have all sources of income and bills directed to SMS, Inc.

Client Signature _____

Date_____