To: Applicants/ Referring Agencies

From: Support Management Solutions, Inc.

RE: Required Referral Information

Thank you for your interest in our organization. Support Management Solutions, Inc.'s Representative Payee Program is dedicated to providing the best possible service to our clients. The following are guidelines that should be followed when making application and/or referrals to SMS, or when making changes to a client's plan that is presently being serviced by our agency. Please see attached forms.

REFERRAL

Part I Referrals should be made in writing containing information as to why the agency is needed to manage the finances of an individual or family. A Physician Statement may be required**.**

Part II Referrals should also include a client profile and disbursement plan. This plan will be adjusted only after consultation with the referral source or case manager. Clients calling to make changes will be referred to the case manager.

Part III Referral should include a Client/ Agency Responsibility Checklist and authorization for release of information.

Part IV To expedite the intake process, referral should include a copy of the following documentation if possible: **driver's license or state issued I.D. card, social security card, Medicaid or Medicare card, lease agreement, recent bank statement, and recent household/utility bills.**

AUTHORIZE FOR RELEASE OF INFORMATION

I HEREBY AUTHORIZE Support Management Solutions, Inc. to release information regarding my case for the purpose of my financial management.

Client Name: _____

Account #: _____

Release to: _____

Information Granted: _____

I HEREBY release the above named parties from any liability for revealing and releasing such information. It is understood that this information, once obtained is not to be released to any other company or individual.

_____ _____

Signature of Client

_____ _____

Date

_____

Signature of Representative for SMS

_____

Date

PART I REASON FOR SERVICE

1. Please give a brief explanation as to why the resources of SMS, Inc. are

needed in this particular situation :

_____
_____
_____

2. What is your disability? :

_____
_____
_____

3. Are there family members or friends available to provide this type of service? :

_____
_____
_____

4. Do you have a court-appointed legal guardian? If yes, please provide name, address and phone number.

Name : _____

Address : _____

Phone : (____) ____-_____

5. Have you previously had a Representative Payee? Yes ☐ No ☐

*** If NO, please have physician form completed.****

Client Signature _____

Printed Signature _____

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 the event my income 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

SMS, 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 : _____

Signature : _____

Date : _____

Part II

Client Name : _____ Date of Birth __/__/_____

Social Security Number : ____-____-_____

Client Address:

_____

_____

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

Client Telephone : (____) ____-_____ Mobile (____) ____-_____

Client Race: _____ Client Marital Status : _____ # of people in home: _____

City and State of Client's Birth:

_____

_____

Maiden Name of Client's Mother : _____

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

Name : _____ Relationship : _____

Name : _____ Relationship : _____

Name : _____ Relationship : _____

Name : _____ Relationship : _____

Name : _____ Relationship : _____

Referring Agency Name: _____
Agency Address:

_____

_____

Case Manager Name : _____
Phone : (____) ____-_____

Email: _____

Next of Kin/Emergency Contact: _____
Relationship: _____

Address:

_____

_____

Telephone : (____) ____-_____ Mobile : (____) ____-_____

Next of Kin/Emergency Contact: _____
Relationship: _____

Address:

_____

_____

Telephone : (____) ____-_____ Mobile : (____) ____-_____

Does the client receive food stamps? Yes ☐ No ☐

Amount : $___,____.__

Medicaid/Medicare : Yes ☐ No ☐

Number : _____

Life Insurance : Yes ☐ No ☐

Company : _____

Term Life Insurance : Yes ☐ No ☐

Premium Amount : $____,____,____.___

Whole-Life Insurance : Yes ☐ No ☐

Premium Amount : $ ____,____,____.____

Cash Value : $____,____,____.____

Any assets (e.g. bank accounts, cars, real estate)? : Yes ☐ No ☐

If so, please list them along with the value:
Bank Account Checking : _____

Bank Account Savings : _____

Vehicle 1 : _____

Vehicle 2 : _____

Real Estate : _____

Real Estate : _____

Misc Value : _____

Has the client ever been convicted of a felony? : Yes ☐ No ☐

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 : _____-____-_____

AVERAGE MONTHLY EXPENSES

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

RENT/MORTGAGE : $_____

WATER and SEWER : $_____

ELECTRICITY : $_____

CABLE : $_____

FOOD : $_____

PERSONAL HYGINE : $_____

PHONE : $_____

GAS/FUEL : $_____

HOUSEHOLD ITEMS : $_____

INSURANCE : $_____

OUTSTANDING DEBTS : $_____

STUDENT LOANS : $_____

Client Signature: _____ Date:_____

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. Support Management Solutions, 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, Wednesday and Thursday 8:30am-4:00pm. Generally, services are not available after 4:00pm, on weekends, or scheduled holidays. ***In office conferences are not available at this time however your payee will meet you either at your case workers offices or at the public library nearest your home.***

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 Support Management Solutions Inc, 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 SMS, 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 : _____

The Social Security Administration (SSA) or Your Case Management Organization has determined that you need a payee. If you want to receive your money yourself, your doctor must be willing to complete a form saying that you can manage your benefits on your own. The goal of working with you as your payee is to assist you in learning more about budgeting, bill paying and, in general, managing your funds so that you can become your own payee. This is what we will work towards with you. If you want to change your payee, let us know. Then, you may go to the SSA office and tell them why you would like your payee to be changed. SSA 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. 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.

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.

Payee Responsibilities

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

2. The payee will work with you collaboratively on an amount for personal expenses to be provided from the balance amount once bills are deducted.

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

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.

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 payee will not pay for bail. Using the benefit for alcohol or drugs is not allowed. Your allowance will be paid WEEKLY by check.
- 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. Checks lost or missing will have a stop pay placed on them and will be replaced in 45 days.
- Generally, with SSI, if your benefits are suspended for 12 months or more, you will need to reapply.

Name of Beneficiary (printed): _____

Name of Beneficiary (signed): _____

Date:_____/_____/_____

Staff Name (printed): _____

Staff Name (signed): _____

Date:_____/_____/_____