



Representative Payee
Services

1-877-447-4082

Everett

Bellingham - Mt. Vernon
Mountlake Terrace

Serving all of Washington

INSTRUCTIONS FOR COMPLETING THE CLIENT INTAKE PACKET

- 1) Please complete and sign all forms included in this packet. All fields are required when applicable.

- 2) If you have not been informed by Social Security that you need a payee and this is the first time applying for a Representative Payee for Social Security benefits, be sure to provide your doctor's information so Social Security can send out form SSA 787 (Physician's Statement of Patient's Capability to Manage Benefits).

- 3) If available, submit copies of 2 forms of identification – preferably 1 photo ID and 1 other form, such as:
 - a. State issued driver's license or identification card
 - b. Social Security Card
 - c. Veteran's Administration identification card

- 4) If possible, provide a copy of insurance cards, including Medicare, Medicaid & ProviderOne.

- 5) In order to assist in developing an accurate budget, please provide copies of the following bills, if applicable:
 - a. Rental agreement – it is **vital** we receive this document immediately. Without a rental agreement, Social Security benefits can be delayed.
 - b. Utilities such as gas, electricity, water, sewer and garbage bills.
 - c. Court fees or fines.



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Client Intake Form

First Name:		Middle Name:	Last Name:		Date:
Street Address:			Mailing Address:		
City:	State:	Zip Code:	City:	State:	Zip Code:
Phone:			SSN:		
Date of Birth:			Place of Birth (City, State & Country):		
Mother's Maiden Name:			Father's Name:		
Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Legally Separated <input type="checkbox"/> Widowed				Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	
If Married, Indicate Spouse's Name and Address (if different):					
Are you a veteran? <input type="checkbox"/> Yes <input type="checkbox"/> No			If Yes, Which Branch of Service:		
Financial Resources (List all types and Monthly Amounts):					
SSI/SSA:	VA:	Pension:	Trust:	Wages:	Other:
Do you receive your benefits as a dependent of another beneficiary? If so, list the <u>beneficiary's Name & SSN</u> :					
Employer's Name (If Applicable):			Employer's Fax # and Contact #:		
Please Indicate The Reason You Are Requesting a Payee: <input type="checkbox"/> Mandated by SSA/VA <input type="checkbox"/> Change in Payee <input type="checkbox"/> Voluntary Enrollment				Referred By:	
Case Worker's Information					
Case Worker's Name/Agency:			Last Visit:		
Address:			E-Mail Address (If Known):		
City:	State:	Zip Code:	Phone Number:		
Guardian / POA Information					
Guardian/POA Name/Agency:					
Address:					
City:	State:	Zip Code:	Phone Number:		

I have no Guardian _____ (if checked please initial)



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Asset Form

Client Name:		SSN:
<p>The Resource limit is \$2000 for a single person and \$3000 for a married couple. The limit applies to <u>SSI and DSHS Only</u>. Mark all that apply. If any are checked fill out section below.</p> <p> <input type="checkbox"/> Checking Account <input type="checkbox"/> Savings Account <input type="checkbox"/> Credit Union <input type="checkbox"/> Trust <input type="checkbox"/> Stocks/Bonds/Mutual Funds/ Brokerage Account <input type="checkbox"/> Real Estate/House/Condo <input type="checkbox"/> Irrevocable Burial Policy <input type="checkbox"/> Life Insurance <input type="checkbox"/> Car/Motorcycle/Boat/Trailer </p>		
Checking, Savings, Credit Unions (If Applicable):		
Name & Location of Financial Institution:		Account Number(s):
Account Holder's Name:		Account Balance:
Trust (If Applicable):		
Name & Location of Financial Institution of Trust:		Account Number(s):
Account Holder's Name:		Trust Amount:
Stocks/Bonds/Mutual Funds/Brokerage Account (If Applicable):		
Name & Location of Financial Institution:		Account Number(s):
Account Holder's Name:		Account Balance:
Burial Policy/Life Insurance (If Applicable):		
Name & Location of Company:		Account Number(s):
Account Holder's Name:		Account Balance:
Real Estate/House/Condo (If Applicable):		
Name & Location of Financial Institution of Lender:		Account Number(s):
Account Holder's Name:		Property Value:
Car/Motorcycle/Boat/Trailer (If Applicable):		
Type:	Make:	Model:
Year:	Value:	



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RENTAL INFORMATION

Client Name:		SSN:	
Type of Rental: <input type="checkbox"/> Room <input type="checkbox"/> Apartment <input type="checkbox"/> House <input type="checkbox"/> Board and Care Facility <input type="checkbox"/> Adult Family Home <input type="checkbox"/> Other _____			
Client Information			
Client Name:		Move-In Date:	
Address:		E-Mail Address (If Applicable):	
City:	State:	Zip Code:	Phone Number:
Landlord Information			
Landlord / Organization Name:			
Address:		E-Mail Address (If Applicable):	
City:	State:	Zip Code:	Phone Number:
Rent Amount: <input type="checkbox"/> Rent Only <input type="checkbox"/> Rent & Utilities		Monthly Rent \$ _____	

_____ I understand that a rent check sent through the mail cannot be guaranteed to arrive at its destination on a certain date.



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Planning Sheet and Next of Kin Information

The WAHOYO Representative Payee Program will use the information provided below in the event of the client's death to administer any funds remaining in his/her account and to assist the next of kin with getting pertinent information for end of life needs. Funds will be disbursed subject to Washington State Law and RCW 11.28.120.			
Client Name:		SSN:	
LAST WILL AND TESTAMENT:			
Do You Have a Will? <input type="checkbox"/> Yes <input type="checkbox"/> No	If so, we suggest that you inform the next of kin listed below about how they can find a copy of your will in the event of your passing.		
BURIAL/CREMATION/PREPLANNING:			
Do You Have a Burial/Cremation Policy:	Does your next of kin know your wishes (i.e., Cremation vs Burial?)		
Which company is it with?	Current Face Value?	Are you Still Making Payments?	
NEXT OF KIN: PRIMARY:			
Name:		Relationship:	
Home Phone:	Work Phone:	Other Phone:	
Address:			
City:		State:	Zip Code:
NEXT OF KIN: SECONDARY: (to be used if we are unable to reach your primary contact):			
Name:		Relationship:	
Home Phone:	Work Phone:	Other Phone:	
Address:			
City:		State:	Zip Code:

NOTE: The next of kin is a person's closest living blood relative. If there is no will, the estate will pass to the next of kin, if there is no surviving spouse, with entitlements passed in the following order: (a) Child or children; (b) father or mother; (c) brothers or sisters; (d) grandchildren; (e) nephews or nieces.

I have no Next of Kin _____(if checked please initial)

Please inform WAHOYO Payee Services of any changes to the information provided herein, including changes to the contact information for your Next of Kin.



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Additional Information

Notes:
Any additional notes or information relevant to the client can go in here:

Disability Type:	
	<p>Cognitive: Usually developmental – trouble with the mental processing involved in gaining knowledge and comprehension. These processes include thinking, knowing, remembering, judging and problem solving. These are higher-level functions of the brain and encompass language, imagination, perception and planning. <i>Intellectual Disability, Autism Spectrum Disorder, Prader Willi, Learning Disorders, Down’s Syndrome, Fetal Alcohol Syndrome,</i></p>
	<p>Mental/Emotional Disorder: Any mental illness or emotional impairment that has substantial adverse effects on an individual’s functions. Mental illness – any of the various forms of psychosis or severe neurosis. Emotional disturbance – major disturbance of emotions. <i>Mood Disorders, Schizophrenia, Anxiety Disorders, Personality Disorders, Oppositional Defiant Disorder, Sleep/Sexual/Gender/Eating Disorders, Substance related disorders, ADHD, ADD</i></p>
	<p>Physical: A physical impairment, a problem in body function or structure that substantially limits one or more of life’s daily activities. <i>Cerebral Palsy, COPD, Degenerative Disc Disease, Diabetes, GERD, Hypothyroidism, Migraines, Seizure Disorder/Epilepsy</i></p>
	<p>Hearing Impairment: A permanent hearing impairment or deafness, loss or decrease in hearing that is so significant that it negatively affects communication and function. <i>Deafness, Hearing Loss</i></p>
	<p>Visual Impairment: A permanent or progressive condition characterized by a lack of or significant decrease of vision which negatively affects daily function and activities. NOT COMPLETE BLINDNESS. This categorized as Blind <i>Retinal Detachment, Cataracts, Glaucoma</i></p>
	<p>Blind: Complete, total or statutory blindness</p>
	<p>Dual Diagnosis: Cognitive disability and a mental illness combination as primary diagnosis. NOT JUST TWO DIFFERENT DISABILITIES <i>Intellectual Disability and Obsessive-Compulsive Disorder; Autism and Anxiety Disorder; Dementia and Depression</i></p>



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Financial Services Contract

I, _____, hereby give Washington Home of Your Own (WAHOYO) Payee Services my authorization to file an application to act as payee on my behalf. I need assistance with financial matters to maintain reasonable control over funds and to provide for my basic needs. WAHOYO has expertise with financial matters and will act as advisor and bookkeeper for me, within certain limits as discussed below. By initialing and signing this form, I acknowledge that I have read and agree to the terms outlined in this contract.

___ I understand that I must be clean and sober while conducting business at WAHOYO offices.

___ I understand that I am expected to treat staff with courtesy and respect. WAHOYO staff is expected to treat me with the same courtesy and respect shown to them.

___ I understand that WAHOYO is not liable for debts of the client in excess of the client's ability to pay. The client is solely liable for debts incurred.

___ I understand that I am only to conduct business with WAHOYO during posted business hours.

___ I give WAHOYO permission to open and sort through any mail that gets forwarded to them on my behalf.

___ I understand that WAHOYO will use funds on my behalf to meet my needs for shelter, food, utilities, and medical care. Any unspent funds not used for personal expenses will be saved in the trust account with Washington Home of Your Own.

___ I understand that if I fail to comply with these rules, Washington Home of Your Own may refuse to continue to serve as my representative payee.

Continued on next page →



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I authorize Washington home of Your Own to provide the service(s) indicated below and I agree to pay the fee associated with this service.

- Social Security – 10% of the client’s monthly income, up to the maximum set by SSA. For 2017 the maximum fee is \$41 per month.
- Private Pay (Wages, Tribal benefits, VA benefits) - \$42 per month
WAHOYO reserves the right to increase the fee at any time.

I further agree that if the entity under which I receive benefits approves a raise of this fee, WAHOYO Payee Services is authorized to take said amount out of my monthly income.

Governing Law and Venue

The laws of the State of Washington shall govern this agreement. If any part of this Vendor Agreement is determined to be unenforceable for any reason, the remaining portions shall remain in to the extent that it is enforceable by law. No amendment or alteration of this Agreement shall be valid unless it is in writing signed and dated by both parties. Any legal disputes resulting from the execution of performance of this agreement shall be brought solely in the Courts of Washington State, and venue shall lie in Snohomish County Superior Court. WAHOYO and the client agree to comply with all applicable Federal, State and Local laws and regulations.

This agreement shall remain in force until services have been terminated.

 Signature of Client

 Date

 Signature of Legal Guardian / POA

 Date

 Washington Home of Your Own Representative Payee

 Date



Washington Home of Your Own
Money Management / Payee Services

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IDENTIFICATION & SOCIAL SECURITY CARDS

Client Name:

Date:

COPY

State/Tribe Issue Identification Card or Driver's License

COPY

Social Security Card

COPY

VA Card or Other ID

Authorized Representative

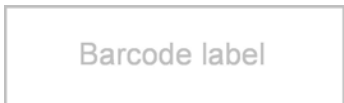
An Authorized Representative is someone you designate to represent you when you apply for or receive benefits with the Department of Social and Health Services (DSHS) or Health Care Authority (HCA). This individual or organization is authorized to act on your behalf for eligibility purposes. Having an authorized representative is optional; DSHS or HCA cannot withhold benefits if you do not sign this form.

Client Information			
NAME		ACES CLIENT ID NUMBER	
Authorized Representative Information			
NAME	ORGANIZATION AND DEPARTMENT (IF APPLICABLE)	PHONE NUMBER (AREA CODE)	
MAILING ADDRESS	CITY	STATE	ZIP CODE
Program and Duration Information			
<p>Which program(s) do you want your authorized representative to act on in your behalf? Check all that apply.</p> <p><input type="checkbox"/> Cash Benefits <input type="checkbox"/> Basic Food Benefits <input type="checkbox"/> Health Care Coverage <input type="checkbox"/> Long-term Care Coverage</p> <p>How long do you want your authorized representative to act on your behalf?</p> <p><input type="checkbox"/> 90 days <input type="checkbox"/> End of certification period (usually one year)</p> <p>You may withdraw or revoke your request for an authorized representative at any time, verbally or in writing, without any impact on benefits.</p>			
Correspondence Information			FOR DEPARTMENT USE ONLY
<p>Please check the level of information or benefits you want your authorized representative to receive.</p> <p><u>For Cash, Basic Food, Health Care Coverage or Long-Term Care (check only one of the four boxes below)</u></p> <p><input type="checkbox"/> Discuss my eligibility for benefits with a DSHS/HCA representative and not receive letters.....</p> <p><input type="checkbox"/> Receive DSHS/HCA letters and discuss my eligibility for benefits.</p> <p><input type="checkbox"/> Receive DSHS/HCA letters, renewal forms and discuss my eligibility for benefits.....</p> <p><input type="checkbox"/> Receive DSHS/HCA letters, renewal forms, payments, ProviderOne cards and discuss my eligibility for benefits</p> <p><u>For Health Care Coverage Only (check either box below if applicable)</u></p> <p><input type="checkbox"/> Hospital representative – receive letters and discuss my eligibility for benefits.....</p> <p><input type="checkbox"/> Sponsor paying premiums. Sponsors name and address sent to Office of Financial Recovery</p>			<p>Rep Type</p> <p>NC</p> <p>NO</p> <p>AD</p> <p>NA</p> <p>HO</p> <p>SB</p>
Client Authorization			
AUTHORIZED BY (CLIENT SIGNATURE)	DATE SIGNED	PRINT NAME	PHONE NUMBER (AREA CODE)

NOTE: HIPAA restrictions prevent us from discussing the client's individual health information with the authorized representative unless the representative has power of attorney for the client or the client has signed a [DSHS 14-012, Consent form](#). This includes disclosure of mental health information, HIV/AIDS and STD test results, or treatment and chemical dependency services.

**FOR DEPARTMENT USE ONLY
INSTRUCTIONS**

Rep Type – ACES does not limit the Rep Type selections to the codes listed above. If a program requires a Rep Type not listed above or if one of the above codes is selected but is not appropriate for the situation (such as for a group home, protective payee, etc.) enter the appropriate program specific Rep Type on the AREP screen.





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AUTHORIZATION FOR RELEASE/DISCLOSURE OF INFORMATION

Name:	SSN:	Date of Birth:
Organization Name:	Account #:	

Authorization for Release of Information:

As evidenced by signature below, this authorization will allow Washington Home of Your Own Payee Services (WAHOYO) to act in all matters on my behalf, including, but not limited to, banking, financial, health care, employment, insurance, burial, trust, social services, utilities & housing. I give my consent for your organization to release any and all information regarding me to WAHOYO as my Social Security appointed, or self-selected, Representative Payee. Further, I give consent for WAHOYO to obtain and/or exchange information, negotiate, discuss, and in any other way, communicate with your organization.

If my medical records contain information regarding diagnosis, treatment, vocational rehabilitation records, or referral for mental illness, drug/alcohol abuse, HIV/AIDS or other sexually transmitted diseases, I give my specific authorization for these records to be released to WAHOYO and understand that the federal or state law prohibits re-disclosure, without specific authorization.

Specific Information Authorized: (select one or more as appropriate)

Any and all financial records pertaining to the client and any accounts(s) referenced above
 Any and all medical records pertaining to client (i.e., hospitalizations, medications, doctor's visits, case narratives, etc.)
 Any and all employee records pertaining to the client (i.e., paystubs, employment dates, wages, etc.)
 Any and all other client related records, including client assets (i.e., banking, insurance, burial, trust, etc.)

Copy in Lieu of Original:

A copy of this authorization shall have the same force and effect as the signed original.

Duration of Authorization:

I authorize the periodic use/disclosure as often as necessary to fulfill the purpose identified in this document. This authorization will remain in effect for as long as I am a client with WAHOYO or until revoked by me in writing. The cancellation will not affect any information that was already disclosed. I am signing this authorization of my own free will.

 Signature of Client

 Date

 Signature of Legal Guardian/POA

 Date

 WAHOYO Payee Services Authorized Agent

 Date



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Now that you've signed up for Payee Service — what happens next?

You will need to provide WAHOYO Payee Services with the following documents **ASAP**:

- A lease at a current house or apartment. If you are buying or own your house, a deed or mortgage statement is needed. **Without this documentation, or if you currently do not have a residence, you will only be provided \$100 per week until a lease is provided or a savings of \$1,500 is conserved.**
- All current bills, with account numbers visible.
- Legal Guardian / POA Paperwork
- Car/Boat, etc. Registration Forms
- Bank Statements (If Applicable)
- You will need to change your billing address for your bills to the following address:
PO BOX 2690
Everett, WA 98213
- The Release of Information (The final page) needs to be mailed to us. We need the original document.

Please keep in mind that it may take up to 2 months for Social Security and/or Veterans Affairs to process the paperwork we filled out today.

As always, please feel free to call us if you have any questions.

Thank you,

Washington Home of Your Own
7003 Evergreen Way
Everett, WA 98203
425-212-4230
payeeservices@wahoyo.org