Community
Action
North
Bay
An End to Homelessness
and Poverty

Community Action North Bay
416 Union Ave. Fairfield, CA 94533 Phone: 707-427-1148 – Fax: 707-427-0468

Payee Services Intake Form

Date: _____ Client Phone Number: _____

Last Name: _____ First Name: _____ Middle Name: _____

Suffix: __ Nickname/ Alias _____ Mother's Maiden Name: _____

Social Security Number _____ Date of Birth: _____ Age: ____

Place of Birth:

City:_____State:_____ County: _____

Last Permanent Address

Address: _____City:_____State:_____Zip code: _____

Current Address

Address: _____City:_____State:_____Zip code: _____

Mailing Address

Address: _____City:._____State:._____Zip code: _____

Are you currently homeless? Yes No

Have you ever received services under a different name? Yes No

If so what name: _____

Have you ever received services under a different social security number? Yes No

If so what number: _____

Marital Status:

___ Single ___ Married ___ Separated ___ Divorced ___ Widowed

Date: ___ _ Date: ___ _ Date: ___ _ Date: ___ _

Do you have any children? Yes No If yes how many: _____

Identification:

Driver's License/Identification Card Number _____ Expiration Date: _____

Medi-Cal Number: _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ Effective Date: _____

Medicare Number: _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ Effective Date: _____

VHJ\ Number: _____ Effective Date: _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _

Social Security Claim Information:

Monthly Benefit .c\.mount: $_____ SSI SSD SSA Retirement

Wages:

Do you work? Yes No Monthly Income$ _____

Name of Employer: _____

Employer Address: _____ City: _____

Employer Phone number: _____ How long have you worked there? _____

Other Benefits:

VA $ _____ Other $ _____

Pension $ _____ Other $ _____

Unearned Income:

Private Pension Dividends Royalties Rental Income

Child Support Alimony Trust Fund Stocks/Bonds

Resources:

Do you have any of the following?

___ Checking Account Bank:_____ Account Number: _____

___ Savings Account Bank:_____ Account Number: _____

Real Estate Vehicles Burial Plot Life Insurance

Emergency Contact:

Last Name:._____ First:._____

Address:_____ City: State: ___ Zip Code:___

Phone Number (home):_____ Phone Number (Cell):._____

Do you have anything else you wish to disclose that might be pertinent to your claim/case?

_____
_____
_____
_____
_____
_____
_____
_____

As a Payee you have agreed to work with the Representative Payee Services Staff to ensure that your funds are utilized in your best interest. In order to do that you ,vill need to ensure that you communicate with staff regarding any changes that may affect your funding.

You need to notify staff if within 3 days if any of the following occur:

General Information:

1. You change your name
2. You get married or divorced
3. You give birth/ have a baby

Residence Changes:

1. You move from your residence or find a residence to live
2. Someone permanently moves in/ out of your residence
3. You enter Jail
   (CANB does not accept collect calls from jail. You will need to have your emergency contact person get a message to CANB staff by phone or mail to notify us only about where you ate incarcerated and when you expect to get out.)

NOTE: If you fail to notify us and money for rent or any other expense is issued, CANB will not be held responsible for any overpayment that occurs.

4. You enter or leave a hospital or skilled nursing facility
5. You change your phone number
6. You leave the state of California

Resource Changes:

1. The amount of alimony or child support you receive or pay changes or stops
2. You inherit or are given money or property
3. You open or close any bank account or receive interest on an account
4. The amount of any benefit checks you receive directly changes
5. You receive money from any other source *(YA,* pension/401k, royalties)
6. Any benefit from any other source stops
7. You start or stop working

NOTE: If your work, you must provide copies of your wage stubs to CANB to submit to the SSA. If you do not provide wage stubs and are penalized later by the SSA for overpayments, CANB will not be held responsible.

8. Purchase a burial plot ot make burial/funeral arrangements
9. Purchase a life insurance policy on yourself or someone else
10. Buy or sell any type of vehicle/transportation
11. Buy or sale any teal-estate or property

Payee Client Signature

Date

Payee Services Representative
Payee Services Contract

I, _____have discussed my needs with Community Action North Bay Payee Services staff and I agree to have them serve as my Representative Payee for:

SSA SSI SSDI Wages VA All

I understand that as my Representative Payee, Community Action North Bay will receive $_____monthly to manage and distribute my funds. I also understand that the Social Security. Administration is responsible for determining the amount my Representative Payee will receive.

As A Payee I Will:

Treat all Community Action North Bay Staff and volunteers with respect
Make and attend all my scheduled meetings with my representative payee
Sign all required documents including but not limited to weekly check allotments, monthly budget
Turn in all receipts that are requested of me
I understand that if I fail to comply with the tules, Community Action North Bay may refuse to serve as my representative payee.

Community Action North Bay Representative Payee Services Will:

Treat me with respect
Be available on the dates of my scheduled meetings
Use funds received on my behalf to meet my needs for shelter, food, clothing and medical care
Report to the Social Security Administration any events that affect my eligibility for benefits
Provide the Social Security Administration with all required documentation on how my money is being spent and/or saved
Save any unspent funds in an account that belongs to me
Comply with all Social Security Administration rules and regulations that involve the distribution of, allocation of or discharge of my benefits.

_____ _____
Payee Client Signature Date

_____ _____
Representative Payee Services Signature Date

Payee Services
Authorization to Release Information

Name: _____

I authorize the exchange of my personnel information between Community Action North Bay, Community Action North Bay Payee Services, The Department of Veterans Affairs, Solano County Health & Human Services, Social Security Administration, Northbay Healthcare of Solano County, Kaiser Permanente, Sutter Solano Medical Center, my personal physician, The Veterans Treatment Court, The Solano County Disttict Attorney's Office, The Solano County Public Defender's Office, Local Law Enforcement, State and Federal Probation Departments, and State and Federal Parole Departments and/ or _____

The following information cm be requested and released: Initial all that apply,
Write N / A on all areas that you wish not to be included

_____Assessments/Evaluations	Medical History	Medications Substance
___ Mental Health History	Abuse History	Financial History
___ Housing History	Employment History	Criminal History

Other (please specify) _____

This authorization is for full disclosure of all records related to the items above.

I understand l:hat such information will only be used for program purposes :related to confirming service eligibility and assessing how to best assist me in receiving services. This information is confidential and will not be released by any of the above stated. agencies to a third party without written permission by me.

I understand that this authorization is valid from my date of entry into the Payee Services Program for the duration of my participation the program. I understand that I have the tight to revoke this authorization at any time by submitting a written. request to the agency releasing the information requested above. l understand that revocation will not apply to information that has already been released.

I understand I have the right to receive a copy of this authorization. ___ Copy requested and issued.

I understand the recipient of this information may not further use, transfer, not re-disclose this information to any person or entity unless another authorization is obtained from me or unless such use or disclosure is specifically required or permitted by law.

Signed: _____ Dated: _____

A photocopy of this authorization is as valid as the original