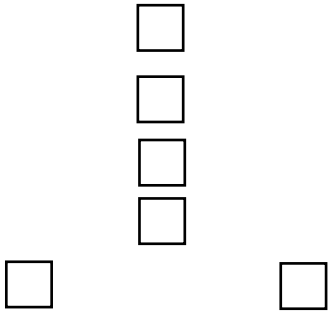

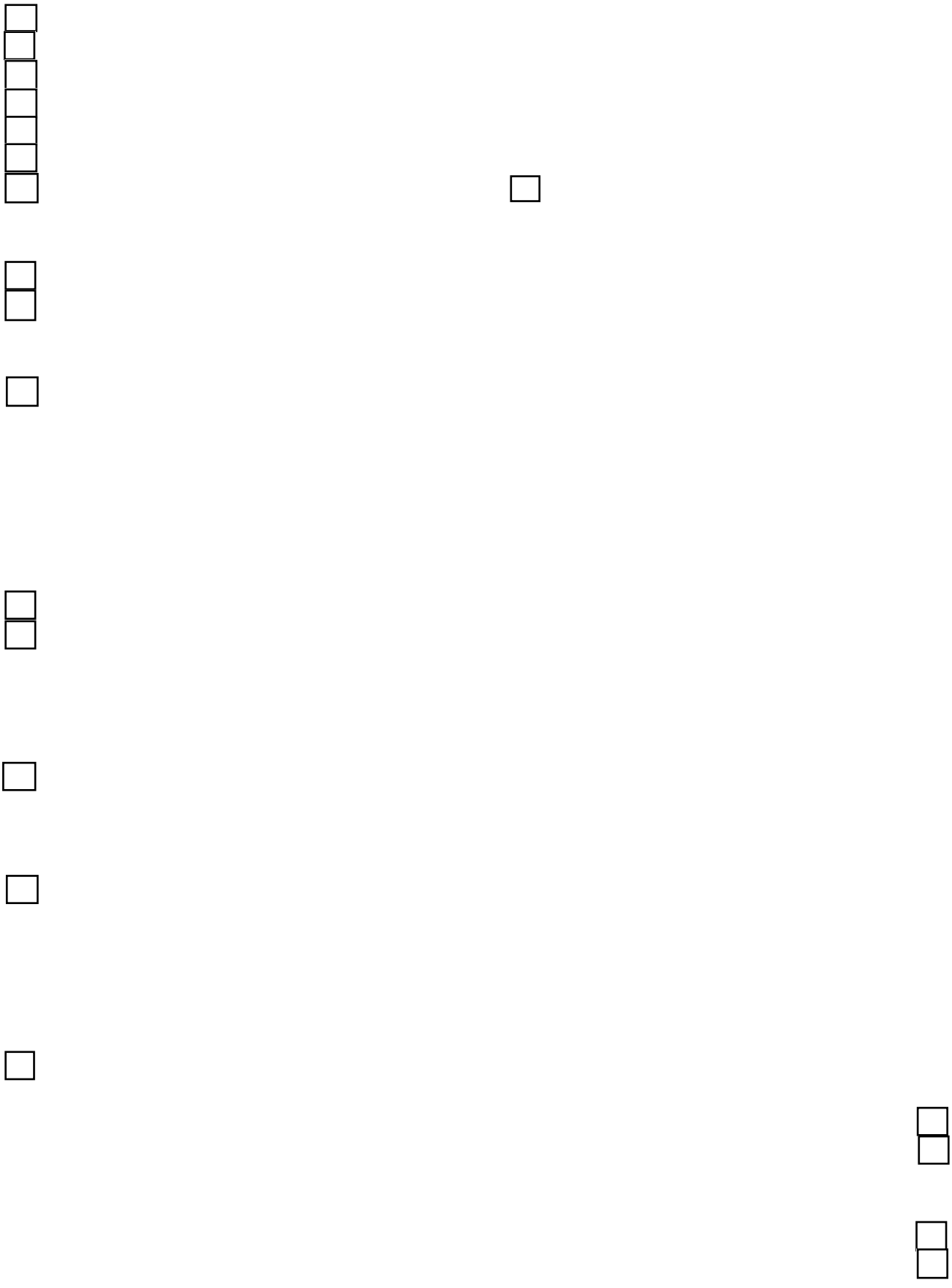

ASSET INFORMATION:			
Savings Account	Bank Name:	Account #:	Value: $
Checking Account	Bank Name:	Account #:	Value: $
Burial Account	Bank Name:	Account #:	Value: $
Burial Plot	Plot Location:		
Life Insurance	Ins. Company:	Policy #:	Value: $

UTILITY INFORMATION:				
Type:	Company Name:	Company Address:	Account #:	Amount:
Electric				
Heat				
Water				
Refuse				
Sewer				
Fine				
Other				
Other				
Other				

PLEASE PROVIDE ANY INFORMATION YOU FEEL WE MAY NEED TO BETTER SERVE YOU:

THE ADVOCACY ALLIANCE APPLICATION PROCESS:

1. The Advocacy Alliance may take up to a week to process the **completed** application into our system.
2. We will then submit the application to the Social Security Adimistration (SSA). Their process may take up to three months to approve payeeship.
3. Once we are approved, we will receive a letter from SSA naming us payee.
4. We will then send the applicant a welcome letter giving further instruction.

OTHER IMPORTANT INFORMATION:

- The purpose of this form is to gather important information about your income and expenses and current money management practices. To ensure timely transition into the program, please complete, sign and return this form through delivery methods listed at the begining of this appliation.
- Once we are payee, if you would like to make a large purchase, you must first get approval from us. This ensures you will have the funds available in your budget.
- We, at no time, repay personal loans. If you borrow money from a friend or relative, you must repay them from your spending check.
- You may request a monthly print out of your account at anytime.

Administrative Offices • 846 Jefferson Avenue • P.O. Box 1368 • Scranton, PA 18501
(T) 570-342-7762 • (TF) 1-877-315-6855 • (F) 570-969-6922 • (E) info@theadvocacyalliance.org • (W) www.theadvocacyalliance.org

AUTHORIZATION FOR RELEASE AND RECEIPT OF INFORMATION

I, _____, give permission to the Advocacy Alliance, which is serving as my Representative Payee, to release and receive pertinent information necessary for the Advocacy Alliance to carry out its representative payee duties in my best interest. This authorization is in effect for as long as the Advocacy Alliance is serving as my Representative Payee.

_____
(Client's Signature)

_____
(Date)

_____
(Witness)

_____
(Date)

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Representative Payee Program

I, _____, hereby request help with my financial affairs from the Advocacy Alliance Representative Payee Program. This aid may include, but is not limited to, check writing, bill paying, bank deposits, and any other assistance that is deemed necessary.

I understand that this service is provided with a charge in accordance to the attached fee schedule and that I may terminate services at any time by either finding another qualified representative payee, or having a physician complete the Physician's Statement of Capability to Manage Benefits form to state that I am able to manage my own financial affairs. This form can be provided to me by the Advocacy Alliance.

_____
Signed

_____
Date

_____
Witness

The Advocacy Alliance
Representative Payee Service
Fee Schedule

Fee 1. Individual referred through county/other agencies (and has community supports) is charged $35.00 per month.

Fee 2. Individual with no referral source (and has no community supports) is charged $37.00 per month.

Fee 3. Individual who is under 18 years of age and whose parent(s) is enrolled in the representative payee program is charged $20.00 per month.

Advance Notification of Representative Payment

Name of Wage Earner, Self-Employed Person or SSI Claimant	Social Security Number
Name of Beneficiary (if other than above)	Relationship to Wage Earner, Self-Employed Person or SSI Claimant

I understand and agree with the following.

Need for Representative Payee

The Social Security Administration (SSA) has decided that I need someone to manage my benefits. Because of this, SSA will send my benefits to a representative payee. It is the duty of the representative payee to use my benefits for my best interests.

Choice of Representative Payee

SSA has selected The Advocacy Alliance to be my representative payee.

My Right to Appeal

I understand that I have the right to appeal SSA's decision. I can appeal the choice of who will be the representative payee. In most cases, I can also appeal the decision that I need a payee. If I appeal, I will have the right to review the evidence in file and submit new evidence. I understand that I can have a friend, lawyer or someone else to help me.

I understand that I must file an appeal within 60 days. If I file after the 60 day period, I must have a good reason for not having filed this appeal on time. I have to ask for the appeal in writing. I will contact an SSA office if I wish to appeal.

Signature	Date

Witnesses are required only if this statement has been signed by mark (X) above. If signed by mark (X), two witnesses to the signing who know the person making the statement must sign below, giving their full addresses.

1. Signature of Witness	2. Signature of Witness
Address (Number and Street, City, State and ZIP Code)	Address (Number and Street, City, State and ZIP Code)

Form **SSA-4164** (9-1994) ef (5-2005)
Destroy Prior Editions

SOCIAL SECURITY ADMINISTRATION | TOE 250 | Form Approved OMB No. 0960-0024

PHYSICIAN'S/MEDICAL OFFICER'S STATEMENT OF PATIENT'S CAPABILITY TO MANAGE BENEFITS

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).** ***Send only comments relating to our time estimate above to:*** *SSA, 6401 Security Blvd, Baltimore, MD 21235-6401.*

In replying, use this address:
SOCIAL SECURITY ADMINISTRATION

TELEPHONE NUMBER (Including Area Code)

DATE

SSA CONTACT

IDENTIFYING INFORMATION (SSA Only)
If different from patient

NAME OF WAGE EARNER OR SELF-EMPLOYED PERSON

SOCIAL SECURITY NUMBER

Privacy Act Statement

Sections 205(a) and 205(j), of the Social Security Act, as amended, author\ze us to collect this information. The information is needed to make a determination regarding whether or not the named individual should be paid benefits directly or whether benefits should be paid to a representative payee. The information you furnish on this form is voluntary. However, failure to provide all or part of the information could prevent an accurate and timely decision on the proper payee for benefit receipt purposes.

We rarely use the information you supply for any purpose other than for making a determination on a claim. However, we may use it for the administration and integrity of Social Security programs. We may also disclose information to another person or to another agency in accordance with approved routine uses, which include but are not limited to: (1) to enable a third party or an agency to assist Social Security in establishing rights to Social Security benefits and/or coverage; (2) to comply with Federal laws requiring the release of information from Social Security records (e.g., to the Government Accountability Office and Department of Veteran Affairs); (3) to make determinations for eligibility in similar health and income maintenance programs at the Federal, state, and local level; and (4) to facilitate statistical research, audit or investigative activities necessary to assure the integrity of Social Security programs.

We may also use the information you provide in computer matching programs. Matching programs compare our records with records kept by other Federal, state or local government agencies. Information from these matching programs can be used to establish or verify a person's eligibility for Federally funded and administered benefit programs and for repayment of payments or delinquent debts under these programs.

A complete list of routine uses for this information is available in Systems of Record Notices 60-0089 and 60-0222. The notices, additional information regarding this form, and information regarding our programs and systems, are available on-line at www.socialsecurity.gov or at your local Social Security office.

PATIENT'S NAME		PATIENT'S ADDRESS (Number and Street, City, State, and ZIP Code)
PATIENT'S SOCIAL SECURITY NUMBER	PATIENT'S DATE OF BIRTH	

YOUR HELP IS NEEDED

The patient shown above has filed for or is receiving Social Security or Supplemental Security Income payments. We need you to complete the back of this form and return it to us in the enclosed envelope to help us decide if we should pay this person directly or if he or she needs a representative payee to handle the funds. Please Note: This determination affects how benefits are paid and has no bearing on disability determinations; SSA will NOT pay for this information. Thank you for your help.

WHO IS A REPRESENTATIVE PAYEE

A representative payee is someone who manages the patient's money to make sure the patient's needs are met. The payee has a strong and continuing interest in the patient's well-being and is usually a family member or close friend.

WHO NEEDS A REPRESENTATIVE PAYEE

Some individuals age 18 and older who have mental or physical impairments are not capable of handling their funds or directing others how to handle them to meet their basic needs, so we select a representative payee to receive their payments. Examples of impairments which may cause incapability are senility, severe brain damage or chronic schizophrenia. However, even though a person may need some assistance with such things as bill paying, etc., does not necessarily mean he/she cannot make decisions concerning basic needs and is incapable of managing his/her own money.

PLEASE COMPLETE THE INFORMATION ON THE REVERSE OF THIS FORM

PATIENT'S NAME		PATIENT'S ADDRESS (Number and Street, City, State, and ZIP Code)
PATIENT'S SOCIAL SECURITY NUMBER	PATIENT'S DATE OF BIRTH	

1. Date you last examined the patient _____

2. Do you believe the patient is capable of managing or directing the management of benefits in his or her own best interest?

   By capable we mean that the patient:

   - Is able to understand and act on the ordinary affairs of life, such as providing for own adequate food, housing, clothing, etc., and
   - Is able, in spite of physical impairments, to manage funds or direct others how to manage them.

☐ Yes	☐ No	☐ Unsure
If "Yes", please omit question 3, but be sure to sign and date the form.	If "No", please provide a brief summary of the findings that led to this conclusion. Also, complete question 3.	If "unsure", please explain.

3. Do you expect the patient to be able to manage funds in the future (for example, the patient is temporarily unconscious)?

   ☐ Yes ☐ No

   If yes, please explain.

NAME OF PHYSICIAN/MEDICAL OFFICER (Please print.)	TITLE
ADDRESS (Number and street, City, State, and ZIP Code)	TELEPHONE NUMBER *(Include Area Code)*

I declare under penalty of perjury that I have examined all the information on this form, and on any accompanying statements or forms, and it is true and correct to the best of my knowledge. I understand that anyone who knowingly gives a false or misleading statement about a material fact in this information, or causes someone else to do so, commits a crime and may be sent to prison, or may face other penalties, or both.

SIGNATURE OF PHYSICIAN/ MEDICAL OFFICER	DATE