Catholic Social Services (CSS) welcomes the opportunity to serve you with our Payee Services. The list below details the required documents needed to process your application for service.

Please note that forms requiring an individual's signature, must be submitted as originally signed forms (no faxed, copied, or emailed forms will be accepted).

Did you submit the following documents? (Please check the box)

- ☐ **Copy of Social Security Card**
- ☐ **Photo ID**
- ☐ **New Client Questionnaire**
- ☐ **Consent for Service**
- ☐ **Release of Information**
- ☐ **Lease &/or Housing Voucher**
- ☐ **Physician's Statement**
- ☐ _____

Please feel free to contact our office with any questions or concerns at 740-452-5057 (ext. 1) or 1-800-536-5057 (ext. 1).

CATHOLIC SOCIAL SERVICES

PAYEE SERVICES
NEW CLIENT QUESTIONNAIRE

Client's Name: _____

Date of Birth: _____ Social Security Number: _____

Client's Address: _____ Phone Number: (_____)_____

City: _____ State: ____ Zip Code: _____ County: _____

Does the client currently have a Payee? **Y** **N** If yes, who? _____

What is the client's income? _____SS _____SSI _____WORK

_____PENSION/RETIREMENT _____OTHER:_____

Does the client have a Guardian? **Y** **N** _____Person _____Estate _____BOTH

Guardian Name/Address/Phone #: _____

_____

What is the client's current living arrangement?

___Lives Alone ___Roommate(s) ___With Family ___Group Home ___OTHER:_____

Arrangement Info: _____

_____

CURRENT RENT AMOUNT: $_____

Landlord Name, Address, & Phone #: _____

_____

Employment History for the past 12 months (Please provide employer information, dates of employment, amount paid each month, & frequency of payment):

_____

_____

Office Use Only: Social Security Mail Date: _____

Direct Deposit Information (checking account):

Routing # _____ Account # _____

Additional Contact Name (Does the client have a case worker, service coordinator, family member, or any other outside services that we could use as secondary contact?) **Y N**

Contact's Name, Agency, & Phone Number: _____

_____

Where does the paperwork need to be sent (address, if different than clients)?

_____

Referral Source:

___ Self ___Outside Agency: _____

___ Other: _____

Additional Information:

_____

_____

_____

_____

_____

_____

_____

_____

_____

CATHOLIC SOCIAL SERVICES

PAYEE SERVICES
CONSENT FOR SERVICE

I, _____, request that Catholic Social Services provide payee services to assist me in the management of my financial situation.

I have the right to choose only those services I wish to receive and the intensity of the services.

I understand that if I have needs that cannot be met by the services provided by Catholic Social Services, my social worker will work with me to find more appropriate services.

I understand that I may discontinue services at any time with no repercussions from Catholic Social Services.

I understand that these services are provided to assist me in the management of my financial situation and I am solely responsible for any financial liability which may apply in this case.

Date: _____ Signature: _____

Date: _____ Witness Signature: _____

Catholic Social Services
PO Box 3446
Zanesville, OH 43702-3446

PAYEE SERVICES

RELEASE OF INFORMATION

Client Name: _____ D.O.B.: _____

Social Security Number: _____

I hereby authorize Catholic Social Services to disclose, release and receive information contained in my client file (current and future documentation) to the listed authorized funders/providers that may assist me with my financial management needs. Any other inquiries must obtain a separate signed release of information.

I understand that my client records/health information (HIPPA) will be kept confidential and released only as need warrants. I also understand that I may revoke this authorization at any time by submitting in writing my decision to revoke.

Authorized funders/providers:

(Name)	(Address)
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

_____ _____

Client Signature Date Witness Signature Date

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

PAPERWORK REDUCTION ACT:

This information collection meets the clearance requirements of 44 U.S.C. §3507, as amended by Section 2 of the Paperwork Reduction Act of 1995. You are not required to answer these questions unless we display a valid Office of Management and Budget control number. We estimate that it will take you about 10 minutes to read the instructions, gather the necessary facts, and answer the questions.

In replying, use this address:
SOCIAL SECURITY ADMINISTRATION

TELEPHONE NUMBER (Include Area Code)
( )

DATE

SSA CONTACT

Privacy Act: This report is authorized by sections 205(a) and 205(j) of the Social Security Act, as amended (42 U.S.C. 405(a) and 405(j). While you are not required to respond, your cooperation will help us decide whether any Social Security benefits that may be due should be paid directly to the patient or to someone else on the patient's behalf. Your cooperation in completing and returning this statement will be appreciated.

We may also use the information you give us when we match records by computer. Matching programs compare our records with those of other Federal, State, or local government agencies. Many agencies may use matching programs to find or prove that a person qualifies for benefits paid by the Federal government. The law allows us to do this even if you do not agree to it. Explanations about these and other reasons why information you provide may be used or given out are available in Social Security Offices. If you want to learn more about this, contact any Social Security Office.

IDENTIFYING INFORMATION (SSA Only)
If different from patient

NAME OF WAGE EARNER OR SELF-EMPLOYED PERSON

SOCIAL SECURITY NUMBER
__ __ __ / __ __ / __ __ __ __

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. 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

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 — If "Yes", please omit question 3, but be sure to sign and date the form.

☐ No — If "No", please provide a brief summary of the findings that led to this conclusion. Also, complete question 3.

☐ Unsure — 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