Hope Ohio
Helping Others Prosper Everday

Hope Ohio, Inc. 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 614-557-7997

PAYEE SERVICES
NEW CLIENT QUESTIONNAIRE

Client's Name: _____

Alias/Nickname: _____

Date of Birth: _____ Social Security Number: _____

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

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

Race? (Optional) _____ Language(s) Spoken _____

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

Does the client have a Guardian? **Y** **N** _____ Person ____ Estate _____ Both

Guardian Name/Address/Phone #: _____

_____

INCOME INFORMATION

What is the client's income? _____ SS _____ SSI _____ WORK

_____ PENSION/RETIREMENT _____ OTHER: _____

If SS or SSI income, is it in suspense? _____

Does applicant receive/have any of the following:

_____ Medicaid _____ Food Stamps _____ Stocks/Bonds _____ Vehicles

_____ Life Insurance/Burial Policies _____ Trust Account _____ Bank Account

Does Applicant have any children? _____ Pay or receive Child Support? _____

Names & Birthdates of Children: (if received child support) _____

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

_____

_____

MARTIAL STATUS / HOUSING INFORMATION

_____ Single _____ Married _____ Divorced _____ Separated

Spouse Name: _____ Spouse Birthdate: _____

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 #: _____

_____

CONTACT INFORMATION

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: _____

_____

_____

_____

Office Use Only: Social Security Mail Date: _____

Direct Deposit Information (checking account):

Routing # _____ Account # _____

PAYEE SERVICES
CONSENT FOR SERVICE

I, _____, request that Hope Ohio 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 Hope Ohio, 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 Hope Ohio.

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: _____

Hope Ohio, Inc.
947 E Johnstown Rd #162
Gahanna, OH 43230

PAYEE SERVICES
RELEASE OF INFORMATION

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

Social Security Number: _____

I hereby authorize Hope Ohio 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

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, authorize 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