

# B&D Payee Services

Name: \_\_\_\_\_  
First Middle Last

Address: \_\_\_\_\_

Mailing: \_\_\_\_\_

Time at current address: \_\_\_\_\_ Phone # \_\_\_\_\_

Social Security Number: \_\_\_\_\_ - - Date of Birth: \_\_\_\_\_

Month/ Day/ Year

Place of Birth: \_\_\_\_\_ Mother's Maiden Name: \_\_\_\_\_

Marital Status: \_\_\_\_\_ Single \_\_\_\_\_ Married \_\_\_\_\_ Widowed \_\_\_\_\_ Divorced \_\_\_\_\_  
Guardian: \_\_\_\_\_ (attach copy of guardianship and why guardian ship was requested)

Guardian Name: \_\_\_\_\_ Relationship to client: \_\_\_\_\_

Guardian Address: \_\_\_\_\_ Guardian Phone #: \_\_\_\_\_

Referred by: \_\_\_\_\_

Disability status: \_\_\_\_\_ Mental Health \_\_\_\_\_ Substance Abuse \_\_\_\_\_ Physical \_\_\_\_\_

Disability Award Date: \_\_\_\_\_ Do you receive SSI \_\_\_\_\_ SSA \_\_\_\_\_ Both \_\_\_\_\_

Employment/other income: \_\_\_\_\_

Client's reported income: \_\_\_\_\_ Date Received: \_\_\_\_\_

Client's current bills:

☐ Rent: \_\_\_\_\_ Name/address \_\_\_\_\_ Date due: \_\_\_\_\_

☐ Power: \_\_\_\_\_ Name/address \_\_\_\_\_ Date due: \_\_\_\_\_

☐ Food: \_\_\_\_\_ Date due: \_\_\_\_\_

☐ Water/Sewer: \_\_\_\_\_ Name/address \_\_\_\_\_ Date due: \_\_\_\_\_

Number of people in the household: \_\_\_\_\_

Name \_\_\_\_\_ Age \_\_\_\_\_ Relationship \_\_\_\_\_

Name \_\_\_\_\_ Age \_\_\_\_\_ Relationship \_\_\_\_\_

Name \_\_\_\_\_ Age \_\_\_\_\_ Relationship \_\_\_\_\_

Name \_\_\_\_\_ Age \_\_\_\_\_ Relationship \_\_\_\_\_

Name \_\_\_\_\_ Age \_\_\_\_\_ Relationship \_\_\_\_\_

Other:

☐ \_\_\_\_\_ Name/address \_\_\_\_\_ Date due: \_\_\_\_\_

☐ \_\_\_\_\_ Name/address \_\_\_\_\_ Date due: \_\_\_\_\_

☐ \_\_\_\_\_ Name/address \_\_\_\_\_ Date due: \_\_\_\_\_

☐ \_\_\_\_\_ Name/address \_\_\_\_\_ Date due: \_\_\_\_\_

☐ \_\_\_\_\_ Name/address \_\_\_\_\_ Date due: \_\_\_\_\_

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☐ \_\_\_\_\_ Name/address \_\_\_\_\_ Date due: \_\_\_\_\_

☐ \_\_\_\_\_ Name/address \_\_\_\_\_ Date due: \_\_\_\_\_

☐ \_\_\_\_\_ Name/address \_\_\_\_\_ Date due: \_\_\_\_\_

Copy of ID / Driver's License: \_\_\_\_\_ (Please Attach)

List of assets of on SSI -(do you own anything/ house/car/land) \_\_\_\_\_

Why Are You Requesting Services? (please do not put because social security said so) \_\_\_\_\_

## **B&D Payee Services**

### **Participation Contract**

I have discussed my needs with staff of B&D Payee Services. I agree to have B&D Payee Services serve as my representative payee for Social Security (SSI or SSDI payments).

#### **Client will:**

- ✓ Be clean and sober when I come to conduct business
- ✓ Treat staff with courtesy and respect
- ✓ Come to conduct business only on (days and hours B&D has set up)
- ✓ Sign a receipt when I receive my spending money (if different than scheduled disbursement)
- ✓ In the event of a financial emergency: Client will contact B&D to request additional funds if available.
- ✓ I understand that if I fail to comply with these rules, B&D may refuse to continue to serve as my representative payee.
- ✓ Call ahead for an appointment. Customers deserve our full attention when they come to our office. Since we serve a large number of people, the only way to guarantee the best one on one service is to set up an appointment. Most businesses can be conducted in one visit; however, additional visits will be set if necessary.
- ✓ Bring all bills, bank statements, pay stubs, and financial questions. We will go over all the finances and make decisions together. If there is anything that the customer does not fully comprehend, we will work together to help answer the questions. We believe that customers have the right to be fully informed about all of their financial matters and we work together to make that happen.
- ✓ Call with your questions. Most questions can usually be answered during office hours with a simple phone call. Please call our office at 276-233-4246. Messages can be left on voicemail and be sure to leave a phone number where you can be reached. Please do not leave more than one message.
- ✓ Treat each other with respect. B&D Payee Services believes that everyone is important. We expect that differences of opinion will be handled in a calm and respectful manner. Since this is a business office, we cannot tolerate yelling, swearing or other disruptive behaviors. If an individual will not discontinue an offensive behavior upon request, B&D Payee Services reserves that right to terminate the payee relationship.
- ✓ Provide one month notice to discontinue service. At any time, either party may discontinue the representative payee service after providing the other party with a one month's notice in writing. This allows us to contact the Social Security Administration about the change and gives the client time to find another payee.

#### **B&D Payee Services will:**

- ✓ Treat clients with courtesy and respect.
- ✓ Be available on business days and business hours to meet with the client.
- ✓ Use funds received on client's behalf to meet client's needs for food and housing.
- ✓ To report to SSA (Social Security Administration) any events that may affect my eligibility for payments or payment amount.
- ✓ Account to SSA on how my money has been spent or saved.
- ✓ Save any unspent funds, if any, in a way that clearly shows the funds belong to me.
- ✓ Return to SSA any funds saved for client (in the event of a change in payee) or that were sent for my benefit but to which the client is not entitled.
- ✓ FEES: \_\_\_\_\_ B&D Fee Based on SSI Notification. Current amount \$55.00 mental/physical amount set by SSA.
- ✓ \_\_\_\_\_ Checks from Truist \_\_\_\_\_.
- ✓ \_\_\_\_\_ Stamps from US Post Office (as needed).
- ✓ For additional information please go to: <http://www.socialsecurity.gov/payee/index.htm>

\_\_\_\_\_  
**Client's signature**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Employee's signature**

\_\_\_\_\_  
**Date**

B&D Payee Services  
1120 Commonwealth Rd., Galax, VA 24333  
276-233-4246 Phone 276-236-8880 Fax

Authorization to Exchange/Release Information  
(for the use and disclosure of client information)

Client's Full Name \_\_\_\_\_

Date of Birth \_\_\_\_\_

Social Security Number \_\_\_\_\_

I, \_\_\_\_\_, authorize **B&D Payee Services** to communicate the following:

- \_\_\_\_\_ Insurance/Billing/Financial
- \_\_\_\_\_ Summary of Participation/Attendance
- \_\_\_\_\_ Summary of Service Received
- \_\_\_\_\_ Other (Specify): \_\_\_\_\_

Which may include the following information, if applicable:

\_\_\_\_\_ Alcohol and/or drug abuse \_\_\_\_\_ AIDS/HIV \_\_\_\_\_ Other Infectious Diseases(e.g. TB, HEP-C, etc.)

For the purpose(s) of:

- \_\_\_\_\_ Service coordination/treatment planning
- \_\_\_\_\_ Eligibility determination
- \_\_\_\_\_ Other: \_\_\_\_\_

As a person signing this authorization to exchange/release information, I acknowledge that I am giving my permission to disclose personal information to the person(s) listed below. I further acknowledge that:

- \* I, the client, may refuse to sign this authorization.
- \* B&D cannot condition the provision of treatment to me on my signing of this authorization.
- \* The original or a copy of this authorization shall be included with my original records.
- \* I have the right to revoke this authorization at any time, except to the extent that action has been taken in reliance on it, by delivering the revocation in writing to the provider who is in possession of my records.
- \* There is a potential for any of information disclosed pursuant to this authorization to be subject to re-disclosure by the recipient and, therefore, no longer protected by the provisions of the HIPAA Privacy Rule.
- \* *If this information is being disclosed from records protected by the Federal substance abuse confidentiality rules (42 CFR Part 2), the Federal rules prohibit the recipient from making any further disclosure of this information unless further disclosure is expressly permitted by your written authorization or as otherwise permitted by 42CFR Part 2. A general authorization for the release of medical or other information is Not sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.*

This Authorization extends to information placed in my record after the date I signed this authorization, unless otherwise requested. This authorization will expire from the date specified, or the following DATE AND/OR EVENT: \_\_\_\_\_ Until Case Is Closed \_\_\_\_\_

Name of person, title, and/or organization allowed to access client's records/information: \_\_\_\_\_

- ☒ Social Security Administration ☒ Truist Bank
- \_\_\_\_\_ Mental Health Agency(please list county) \_\_\_\_\_
- \_\_\_\_\_ Social Services (please list county) \_\_\_\_\_

Client's signature \_\_\_\_\_

Date \_\_\_\_\_

Client's Parent, Legal Guardian \_\_\_\_\_ Date  
Or Legal Representative \_\_\_\_\_

Basis of Representative's authority to sign Authorization on behalf of the client (e.g. parent, guardian, etc.) \_\_\_\_\_

Witness Signature (If needed) \_\_\_\_\_

Date \_\_\_\_\_



## 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 B&D Payee Services 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)

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