Representative Payee Application

Thank you for your interest in our organization. Origin SC's Representative Payee Program is dedicated to providing the best possible service to our clients. Please complete this form with as much information as possible. If unknown or N/A, please notate. Someone from our agency will reach out you to let you know we have received the application and gather any more needed information.

Part I Agency Information

1.1 Referring agency name_____ 1.2 Referring agency address_____

1.3 Agency contact name_____ 1.4 Agency contact phone _____

1.5 Agency contact Email _____

PART II CLIENT INFORMATION

2.1 Client name: First _____ Last _____

2.2 Client date of birth_____2.3 Client social security number_____

2.4.1 Please describe the clients Current living Situation:

2.4.2 Please provide an address or additional information if no address.

Street address_____

City_____ State_____ Zip code_____

2.5 Current rent amount_____ 2.6 Number of People in home_____

2.7 How long has client lived at this address? _____

2.8 Name and relationship of all persons living with client

2.9 Former address (if known)

2.10 Client email_____ 2.11 Client phone number_____

2.12 Client Marital Status_____ 2.13Client Race_____

*2.14 City and State of Client's Birth_____

*2.15 Client's Mothers maiden name_____

2.16 Emergency contact Name _____2.17 Relationship to Client_____

2.18 Emergency Contact Phone #_____

2.19Emergency Contact Address_____

2.20 Does client receive food stamps? _____ 2.21 If yes how much_____

2.22 Medicare Number_____ 2.23 Medicaid number_____

Monthly Income

SSDI $_____

SSI $_____

VA Benefit $_____

Other monthly income $_____

PART III REASON FOR SERVICE

3.1 Please explain why the client is not able to manage his/her own finances.

3.2 Please list client disabilities, if any

3.3 Are there any family members or friends willing and able to serve as payee?

3.4 Does the client have a court-appointed legal guardian? If yes, please provide their name, address, and phone number.

5. Have you previously had a Representative Payee? ☐ Yes ☐ No **** If NO, please have physician form completed. ****

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PART IV CLIENT/ AGENCY RESPONSIBILITY CHECKLIST

Name _____ **SSN** _____

My signature indicates the following items have been discussed with me to my satisfaction and any questions have been answered.

Family Services, Inc. DBA Origin SC (Agency) rules have been explained:
Services are made available to clients without regard to race, religion, creed, or origin.

The Agency's expectations of me have been explained:
A client is expected to provide truthful, accurate information to the best of his/her knowledge. The client needs to notify the Agency when changes occur in health, living arrangements (including incarceration/hospitalization), or employment and income.

My rights and responsibilities as a client have been explained:
A client has the right to confidential treatment of information provided to any Agency staff member. The client's responsibility is to provide adequate, accurate information so that the agency will provide efficient service to meet client needs.

Hours of service availability have been explained to me:
Agency hours are **Monday – Thursday, 8:00 a.m. – 5:00 p.m. Friday 8:00 a.m. – 4:00 p.m..** Generally, services are not available after 5:00 p.m., on weekends, or scheduled holidays. **In office conferences are done by appointment.**

The Grievance procedure, to follow when a violation of a client's rights has occurred, has been explained. Stage 1: Within 30 days of incident of complaint, there should be an informal discussion with the service staff directly involved. Stage 2: Within 14 days of stage 1, a written complaint should be submitted to Origin SC, Attention: Director of Financial Management Representative Payee Program. A response from the Program director will be given within 14 working days of complaint. Stage 3: A formal appeal to Origin SC addressed to Executive Director must be filed within 14 days of completing stage 2. The Executive Director will give a response within 14 days.

I agree to release any information from Origin SC to any agency who is acting in an advocacy role to work for the benefit of my finances. I agree to have all sources of income and bills directed to Family Services, Inc. DBA Origin SC.

Client Signature _____ **Date** _____

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AUTHORIZATION TO RELEASE INFORMATION

I am currently working with the Representative Payee Department, Family Services, Inc. DBA Origin SC. **I hereby authorize you to release any and all information concerning my financial information, verbally, written and otherwise, to Origin SC at the counselors' request.**

☐ give Origin SC permission to share my personal and financial information with outside resources that the counselor feels would be helpful in improving my financial situation: including but not limited to – DSS/Dept. of Mental Health caseworkers, landlord/property managers, Social Security offices, caretakers, etc. I understand that I am not obligated to use any of the services offered to me.

Fraud Policy

Family Services, Inc. DBA Origin SC (the Company) is committed to preventing, identifying, and reporting any fraudulent activity related to the Company's services, activities and administration of grants. Fraud may include but is not limited to false statements provided by or to staff, contractors, clients, beneficiaries and stakeholders. Fraudulent activities may include but are not limited to knowingly misrepresenting income or expenses, assisting or counseling anyone to misrepresent facts or circumstances related to eligibility for programs or benefits, bribery, kickbacks, theft or embezzlement, forgery or alteration of documents, destruction or concealment of records, profiting from insider knowledge, or a conflict of interest. The Company will investigate any reports of fraud. The Company reserves the right to involve law enforcement authorities in its investigation. Any documented fraudulent activity may result in administrative or criminal action being taken against those involved including termination from any program sponsored by the Company or termination from employment by the Company. The Company will not retaliate against any party who reports fraud, criminal activities or other program irregularities. Any suspected fraudulent activity should be reported to the Company's currently appointed Risk Manager with sufficient specificity to facilitate an investigation.

_____ _____ _____

Client's Signature **Print Name** **Last 4 of Social**

Date _____

_____ _____ _____

Origin SC Counselor Signature **Print Name** **Date**