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 Voices of Inspiration North Representative 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)	Address (Number and Street, City, State and ZIP Code)

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

VOICES OF INSPIRATION NORTH

NEW CLIENT PERSONAL INFORMATION FORM

PERSONAL INFORMATION:

NAME: _____ **SSN:** ____ / ____ / ____

DATE OF BIRTH: _____ AGE: _____

PLACE OF BIRTH:
(City & State)

MARITAL STATUS: Married ____ Divorced ____ Separated____ Single____
Widowed ____

IF MARRIED:
SPOUSES NAME:_____SPOUSE'S AGE:_____

SPOUSES SSN: _____ __

CURRENT HOUSING/LIVING ARRANGEMENTS:

I LIVE IN A: House____Apt____ Room in A Private Home____ Room & Board____
Board & Care Facility____Motel/Hotel____ Mobile Home____ I Am Homeless ____

CURRENT ADDRESS: _____APT #: _____
CITY/STATE/ZIP: _____
PHONE NUMBER: _____

HOW LONG HAVE YOU LIVED AT YOUR CURRENT ADDRESS: _____ _____
Since (Month) (Year)

HOW MUCH IS YOUR MONTHLY RENT/ROOM & BOARD/Board & CARE: $_____

NAME OF LANDLORD: _____
LANDLORD'S ADDRESS: _____
_____

LANDLORD'S PHONE NUMBER: _____

ARE YOU RELATED TO THE LANDLORD/ROOM& BOARD/BOARD & CARE PROVIDER: Yes____No____

IF YES, WHAT IS RELATIONSHIP: _____

CURRENT HOUSEHOLD COMPOSITION:

I LIVE (WITH) Alone_____ Children_____ Spouse_____ Parent(s)_____
With A Relative_____ Others_____

DO YOU HAVE ANY DEPENDENT CHILD(REN) WHO CURRENTLY LIVE WITH YOU:

Yes_____ No_____

IF YOU HAVE DEPENDENT CHILD(REN) WHO LIVE WITH YOU, LIST NAMES, AGES & SSN'S FOR ALL DEPENDENT CHILDREN WHO LIVE WITH YOU:

NAME_____ DATE OF BIRTH_____ AGE_____ SSN:_____
NAME_____ DATE OF BIRTH_____ AGE_____ SSN:_____
NAME_____ DATE OF BIRTH_____ AGE_____ SSN:_____
NAME_____ DATE OF BIRTH_____ AGE_____ SSN:_____
NAME_____ DATE OF BIRTH_____ AGE_____ SSN:_____
NAME_____ DATE OF BIRTH_____ AGE_____ SSN: _____

DO ANY OF YOUR DEPENDENT CHILD(REN) RECEIVE:

AFDC/TANF_____ SSA_____ SSI_____ VA Pension_____

IF YOU LIVE WITH A RELATIVE OR FRIEND, LIST NAME OF ALL RELATIVES & FRIENDS:

NAME:_____ RELATIONSHIP:_____
NAME:_____ RELATIONSHIP:_____
NAME:_____ RELATIONSHIP:_____
NAME:_____ RELATIONSHIP: _____

DO ANY OF YOUR RELATIVES/FRIENDS, WHO YOU LIVE WITH, RECEIVE: AFDC/TANF_____
SSA_____ SSI_____ VA Pension_____

DO YOU EXPECT YOUR LIVING ARRANGEMENTS OR HOUSEHOLD COMPOSITION TO CHANGE:

YES_____ **NO**_____

IF YES, PLEASE EXPLAIN :_____
_____

INCARCERATION/HOSPITALIZATION:

HAVE YOU BEEN INCARCERATED (IN JAIL) MORE THAN 30 DAYS DURING THE LAST 12 MONTHS?:
YES_____NO_____
IF YES: EXPLAIN _____

HAVE YOU BEEN HOSPITALIZED MORE THAN 30 DAYS DURING THE LAST 12 MONTHS? YES_____NO _____
IF YES: EXPLAIN _____

CURRENT BENEFITS & PAYEE STATUS

HAVE YOU RECEIVED A NOTICE FROM SOCIAL SECURITY THAT YOU OWE AN OVERPAYMENT? Yes_____No_____
IF YES: EXPLAIN _____

DO YOU CURRENTLY HAVE A PAYEE: Yes_____No _____
NAME OF PAYEE: _____
PAYEE ADDRESS: _____
PAYEE PHONE #: _____

WHY DO YOU WANT TO CHANGE FROM YOUR CURRENT PAYEE? _____
_____

EMERGENCY CONTACTS: To be used as an alternate contact to reach you in an emergency

NAME:_____ RELATIONSHIP: _____
ADDRESS:_____
CITY/STATE/ZIP:_____
PHONE: _____

NAME: _____ RELATIONSHIP: _____
ADDRESS:_____
CITY/STATE/ZIP:_____
PHONE: _____

CURRENT CASEWORKER/SOCIAL WORKER: To be used for emergency contact to reach in-home supportive service staff, mental health, and or drug & alcohol treatment & counselors

NAME: _____
ORGANIZATION:_____
ADDRESS:_____
PHONE: _____

DESIGNATED BENEFICIARY: In the case of your death, list the individual(s) whom you would name as the beneficiary to any funds you are entitled to and have on account.

NAME:_____ RELATIONSHIP:_____
ADDRESS: _____
CITY/STATE/ZIP: _____
PHONE NUMBER: _____
RELATIONSHIP TO YOU: _____

******************* CHANGES THAT MUST BE REPORTED TO VOIN *******************

I understand that certain circumstances can affect my eligibility for benefits and the amount of those benefits. I understand **I must report any of the following**:

- I get a job or stop working
- I move
- I get married
- I get money from another source
- I take a trip outside the United States
- I go to jail or prison
- I am admitted to a hospital
- I save any money
- I apply for assistance from a welfare agency or other government source
- I am no longer disabled

FEE FOR SERVICE ACKNOWLEDGEMENT:

I_____ understand that Voices of Inspiration North (VOIN) Payee Service charges a monthly fee of 10% of my benefit not to exceed $44 per month for management of my SSI/SSA benifits.

_____ _____
CLEINT SIGNATURE DATE

In event the above beneficiary has marked their signature by "X", a Witness Signature is required

_____ _____
WITNESS SIGNATURE DATE

APPLICATION FOR CALIFORNIA RESTAURANT MEALS ALLOWANCE

(Application for Optional Supplement Variation C – Independent Living Arrangement Without Cooking Facilities)

Applicant/Recipient's Name **SSN**

I (we) am (are) applying for the Restaurant Meals Allowance and understand that to be eligible the following requirements must be met:

1. I do not receive meals as part of my living arrangement, and

2. Beginning _____ one of the following conditions exists: (check one)
(month, day, year)

☐ I do not have access to a working refrigerator or icebox.

☐ My cooking facilities are inadequate; I do not have access to: a working oven (regular or microwave) plus at least one temperature controlled heating unit, or at least two temperature controlled heating units (but no functioning oven).

☐ My cooking or food storage facilities are temporarily not working and are not expected to be working until _____.
date

I certify the above to be true and know that providing false statements or misrepresentation of fact is punishable under Federal and/or State law.

I understand that the California Restaurant Meals Allowance ends the month following the month in which I start receiving meals as a part of my living arrangement or have access to adequate cooking and food storage facilities.

I agree to immediately notify Social Security if there is any change in my living arrangement as described above.

Signed:_____ Date_____

Signed:_____ Date_____
(spouse if applying or eligible)

SSA Decision: ☐ Approved effective_____
NOTE: Date cannot be earlier than protected filing date (initial claims) or date applicant/recipient reported a COA

☐ Denied, Notice of Planned Action Provided (Redetermination only)

By: Signed _____Title _____ Date _____

SSA Office _____

SOCIAL SECURITY ADMINISTRATION
STATEMENT OF CLAIMANT OR OTHER PERSON

NAME OF WAGE-EARNER, SELF EMPLOYED PERSON, OR SSI CLAIMANT	SOCIAL SECURITY NUMBER
NAME OF PERSON MAKING STATEMENT	**RELATIONSHIP**
	LANDLORD (ROOM RENTAL)

Understanding that this statement is for the use of the Social Security Administration, I hereby certify that -

I RENT A ROOM TO _____. HE/SHE PAYS

$_____PER MONTH EFFECTIVE WITH _____(MM/DD/YY)

_____DOES NOT MAKE ANY OF THE HOUSEHOLD DECISIONS.

HE/SHE (circle one) DOES/DOES NOT HAVE ACCESS TO STORAGE AND COOKING

FACILITIES.

_____DOES/DOES NOT BUYS HIS/HER OWN FOOD.

CLIENTS SIGNATURE_____

LANDLORD ON SSI, GA or AFDC: YES_____NO_____

LANDLORD'S SSN:_____-_____-_____

I know that anyone who makes or causes to be made a false statement or representation of material fact in an application or for use in determining a right to payment under the Social Security Act commits a crime punishable under Federal Law and/or State Law. I affirm that all information I have given in this document is true.

SIGNATURE OF PERSON MAKING STATEMENT

Signature	Date
➔	

Mailing Address

City and State	Zip	Telephone Number

Form SSA-795

SOCIAL SECURITY ADMINISTRATION
STATEMENT OF CLAIMANT OR OTHER PERSON

NAME OF WAGE-EARNER, SELF EMPLOYED PERSON, OR SSI CLAIMANT	SOCIAL SECURITY NUMBER
NAME OF PERSON MAKING STATEMENT	**RELATIONSHIP**
	LANDLORD (PARENT/CHILD)

Understanding that this statement is for the use of the Social Security Administration, I hereby certify that -

_____IS A SEPARATE HOUSEHOLD. HE/SHE PAYS

$_____PER MONTH EFFECTIVE WITH _____(MM/DD/YY)

_____DOES NOT MAKE ANY OF THE HOUSEHOLD DECISIONS.

HE/SHE (circle one) DOES/DOES NOT HAVE ACCESS TO STORAGE AND

COOKING FACILITIES. _____BUYS HIS/HER OWN FOOD. IF I

WERE TO RENT THIS ROOM TO SOMEONE OTHER THAN A FAMILY MEMBER, I

WOULD CHARGE $_____PER MONTH.

CLIENTS SIGNATURE_____

LANDLORD'S SSN:_____-_____-_____

LANDLORD ON SSI, GA or AFDC: YES_____NO_____

I know that anyone who makes or causes to be made a false statement or representation of material fact in an application or for use in determining a right to payment under the Social Security Act commits a crime punishable under Federal Law and/or State Law. I affirm that all information I have given in this document is true.

SIGNATURE OF PERSON MAKING STATEMENT

Signature	Date
➔	

Mailing Address

City and State	Zip	Telephone Number

Form SSA-795

APPLICATION FOR CALIFORNIA RESTAURANT MEALS ALLOWANCE

(Application for Optional Supplement Variation C – Independent Living Arrangement Without Cooking Facilities)

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(month, day, year)

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Signed:_____ Date_____

Signed:_____ Date_____
(spouse if applying or eligible)

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NOTE: Date cannot be earlier than protected filing date (initial claims) or date applicant/recipient reported a COA

☐ Denied, Notice of Planned Action Provided (Redetermination only)

By: Signed _____Title _____ Date _____

SSA Office _____

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. To find the nearest office, call 1-800-772-1213.** Send **only** comments on 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

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; **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

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

*U.S. Government Printing Office: 2005—310-828/00544