We are excited to announce that Washington Home Of Your Own will now be doing business as…

Journey Housing & Payee Services

Your pathway to stability

New name, same great service!

Please note: Other than new letterhead, no changes have been made to our representative payee application that follows. Call us if you have questions!

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INSTRUCTIONS FOR COMPLETING THE CLIENT INTAKE PACKET

1) Please complete and sign **all** forms included in this packet. All fields are required when applicable.

2) If you have not been informed by Social Security that you need a payee and this is the first time applying for a Representative Payee for Social Security benefits, be sure to provide your doctor's information so Social Security can send out form SSA 787 (Physician's Statement of Patient's Capability to Manage Benefits).

3) If available, submit copies of 2 forms of identification – preferably 1 photo ID and 1 other form, such as:
   a. State issued driver's license or identification card
   b. Social Security Card
   c. Veteran's Administration identification card

4) If possible, provide a copy of insurance cards, including Medicare, Medicaid & ProviderOne.

5) In order to assist in developing an accurate budget, please provide copies of the following bills, if applicable:
   a. Rental agreement – it is **vital** we receive this document immediately. Without a rental agreement, Social Security benefits can be delayed.
   b. Utilities such as gas, electricity, water, sewer and garbage bills.
   c. Court fees or fines.

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Client Intake Form

First Name:	Middle Name:	Last Name:	Date:

Street Address:			Mailing Address:		
City:	State:	Zip Code:	City:	State:	Zip Code:
Phone:			SSN:		
Date of Birth:			Place of Birth (City, State & Country):		
Mother's Maiden Name:			Father's Name:		
Marital Status: ☐ Single ☐ Married ☐ Divorce ☐ Legally Separated ☐ Widowed			Gender: ☐ Male ☐ Female		
If Married, Indicate Spouse's Name and Address (if different):					
Are you a veteran? ☐ Yes ☐ No			If Yes, Which Branch of Service:		

Financial Resources (List all types and Monthly Amounts)

SSI/SSA:	VA:	Pension:	Trust:	Wages:	Tribal:

Do you receive your benefits as a dependent of another beneficiary? If so, list the beneficiary's Name & SSN:	
Name of Financial Resource:	Resource Fax # and Contact #:
Please Indicate The Reason You Are Requesting a Payee: ☐ Mandated by SSA ☐ Change in Payee ☐ Voluntary Enrollment	How Were You Referred to Journey?

Case Worker's Information

Case Worker's Name/Agency:		Last Visit:	
Address:		E-Mail Address (If Known):	
City:	State:	Zip Code:	Phone Number:

Guardian / POA Information

Guardian/POA Name/Agency:		☐ Power of Attorney ☐ Guardian	
Address:			
City:	State:	Zip Code:	Phone Number:

☐ I have no guardian. **If checked, please initial. _____**

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Assets & Bills

Client Name:	SSN:

The Resource limit is $2000 for a single person and $3000 for a married couple. The limit applies to SSI and DSHS Only.
Mark all that apply. If any are checked fill out section below.

☐ **Checking Account** ☐ **Savings Account** ☐ **Credit Union** ☐ **Burial Policy** ☐ **Life Insurance**
☐ **Car/Motorcycle/Boat/Trailer**

Checking/Savings/Credit Unions	
Name & Location of Financial Institution:	**Account Number(s):**
Account Holder's Name:	**Account Balance:**

Burial Policy/Life Insurance	
Name & Location of Company:	**Account Number(s):**
Account Holder's Name:	**Account Balance:**

Car/Motorcycle/Boat/Trailer		
Type:	**Make:**	**Model:**

List Bills Below	
TV/Internet	
Name of Company:	**Account Number:**
Account Holder's Name:	**Average Monthly Amount:**
Home/Cell Phone	
Name of Company:	**Account Number:**
Account Holder's Name:	**Average Monthly Amount:**
Electricity/Water/Sewer/Garbage/Gas	
Name of Company:	**Account Number:**
Account Holder's Name:	**Average Monthly Amount:**
Court Fines / Insurance / Medical / Other	
Name of Company:	**Account Number:**
Account Holder's Name:	**Average Monthly Amount:**
Court Fines / Insurance / Medical / Other	
Name of Company:	**Account Number:**
Account Holder's Name:	**Average Monthly Amount:**

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RENTAL INFORMATION

Client Name:		**SSN:**	
Type of Rental: ☐ **Room** ☐ **Apartment** ☐ **House** ☐**Board and Care Facility** ☐ **Adult Family Home** ☐ **Other** _____			
Client Information			
Client Name:		**Move-In Date:**	
Address:		**E-Mail Address (If Applicable):**	
City:	**State:**	**Zip Code:**	**Phone Number:**
Landlord Information			
Landlord / Organization Name:			
Address:		**E-Mail Address (If Applicable):**	
City:	**State:**	**Zip Code:**	**Phone Number:**
Rent Amount: ☐ **Rent Only** ☐ **Rent & Utilities**		**Monthly Rent $**_____	

_____ (Initial) **I understand that a rent check sent through the mail cannot be guaranteed to arrive at its destination on a certain date.**

_____ _____

Signature of Client Date

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Planning Sheet and Next of Kin Information

The Journey Representative Payee Program will use the information provided below in the event of the client's death to administer any funds remaining in his/her account and to assist the next of kin with getting pertinent information for end of life needs. Funds will be disbursed subject to Washington State Law and RCW 11.28.120.			
Client Name:		**SSN:**	
LAST WILL AND TESTAMENT			
Do You Have a Will? ☐ **Yes** ☐ **No**	If so, we suggest that you inform the next of kin listed below about how they can find a copy of your will in the event of your passing.		
BURIAL/CREMATION/PREPLANNING			
Do You Have a Burial/Cremation Policy:	**Does your next of kin know your wishes** (i.e., Cremation vs Burial?)		
Which company is it with?	**Current Face Value?**	**Are you Still Making Payments?**	
PRIMARY NEXT OF KIN			
Name:		**Relationship:**	
Home Phone:	**Work Phone:**	**E-Mail Address:**	
Address:			
City:		**State:**	**Zip Code:**
SECONDARY NEXT OF KIN (to be used if we are unable to reach your primary contact)			
Name:		**Relationship:**	
Home Phone:	**Work Phone:**	**E-Mail Address:**	
Address:			
City:		**State:**	**Zip Code:**

NOTE: The next of kin is a person's closest living blood relative. If there is no will, the estate will pass to the next of kin, if there is no surviving spouse, with entitlements passed in the following order: (a) Child or children; (b) father or mother; (c) brothers or sisters; (d) grandchildren; (e) nephews or nieces.

☐ **I have no Next of Kin** _____(if checked please initial)

Please inform Journey Payee Services of any changes to the information provided herein, including changes to the contact information for your Next of Kin.

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Additional Information

Please Give a Brief Explanation of Why You Are Applying for a Payee

	Disability Type
☐	**Cognitive:** Usually developmental – trouble with the mental processing involved in gaining knowledge and comprehension. These processes include thinking, knowing, remembering, judging, and problem solving. These are higher-level functions of the brain and encompass language, imagination, perception and planning. *Intellectual Disability, Autism Spectrum Disorder, Prader Willi, Learning Disorders, Down's Syndrome, Etc.*
☐	**Mental/Emotional Disorder:** Any mental illness or emotional impairment that has substantial adverse effects on an individual's functions. Mental illness – any of the various forms of psychosis or severe neurosis. Emotional disturbance – major disturbance of emotions. *Mood Disorders, Schizophrenia, Anxiety Disorders, Personality Disorders, Sleep/Sexual/Gender/Eating Disorders, ADHD/ADD, Substance Abuse Disorders*
☐	**Physical:** A physical impairment, a problem in body function or structure that substantially limits one or more of life's daily activities. *Cerebral Palsy, COPD, Degenerative Disc Disease, Diabetes, GERD, Hypothyroidism, Migraines, Seizure Disorder/Epilepsy*
☐	**Hearing Impairment:** A permanent hearing impairment or deafness, loss or decrease in hearing that is so significant that it negatively affects communication and function. *Deafness, Hearing Loss*
☐	**Visual Impairment:** A permanent or progressive condition characterized by a lack of or significant decrease of vision which negatively affects daily function and activities. NOT COMPLETE BLINDNESS. This categorizes as Blind. *Retinal Detachment, Cataracts, Glaucoma*
☐	**Blind:** Complete, total or statutory blindness
☐	**Dual Diagnosis:** Cognitive disability and a mental illness combination as primary diagnosis. NOT JUST TWO DIFFERENT DISABILITIES *Intellectual Disability and Obsessive-Compulsive Disorder; Autism and Anxiety Disorder; Dementia and Depression*

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Financial Services Contract

I, (print name)_____ , hereby give Journey Housing & Payee Services (Journey) Payee Services my authorization to file an application to act as payee on my behalf. I need assistance with financial matters to maintain reasonable control over funds and to provide for my basic needs. Journey has expertise with financial matters and will act as advisor and bookkeeper for me, within certain limits as discussed below. By initialing and signing this form, I acknowledge that I have read and agree to the terms outlined in this contract.

Please initial each line after you read it.

__I understand that I must be clean and sober while conducting business at Journey offices.

___I understand that I am expected to treat staff with courtesy and respect. Journey staff is expected to treat me with the same courtesy and respect shown to them.

__I understand that Journey is not liable for debts of the client in excess of the client's ability to pay. The client is solely liable for debts incurred.

__I understand that I am only to conduct business with Journey during posted business hours.

___I give Journey permission to open and sort through any mail that gets forwarded to them on my behalf.

___ I understand that there is a limit of $1,500/week maximum total withdrawal unless otherwise approved by the payee.

___ I understand that documentation will be required for any single check request for $5,000 – or otherwise specified by payee – before the check will be issued.

___ I understand that any client receiving Social Security benefits will be required to provide receipts & documentation for any single purchase over $100, or as otherwise requested by payee.

__I understand that Journey will use funds on my behalf to meet my needs for shelter, food, utilities, and medical care. Any unspent funds not used for personal expenses will be saved in the trust account with Journey Payee Services.

__I understand that if I fail to comply with these rules, Journey Payee Services may refuse to continue to serve as my representative payee.

I authorize Journey Payee Services to provide the service(s) indicated herein and I agree to pay the fee associated with this service.

- Social Security – 10% of the client's monthly income, up to the maximum set by SSA. For 2018 the maximum fee is $42 per month.
- Private Pay (Wages, Tribal benefits, VA benefits) - $45 per month

  Journey reserves the right to increase the private pay fee at any time.

I further agree that if the entity under which I receive benefits approves a raise of this fee, Journey Payee Services is authorized to take said amount out of my monthly income.

Governing Law and Venue

The laws of the State of Washington shall govern this agreement. If any part of this Vendor Agreement is determined to be unenforceable for any reason, the remaining portions shall remain in to the extent that it is enforceable by law. No amendment or alteration of this Agreement shall be valid unless it is in writing, signed and dated by both parties. Any legal disputes resulting from the execution of this agreement shall be brought solely in the Courts of Washington State, and venue shall lie in Snohomish County Superior Court. Journey and the client agree to comply with all applicable Federal, State and Local laws and regulations.

This agreement shall remain in force until services have been terminated.

Signature of Client	Date
Signature of Legal Guardian / POA	Date
Journey Housing & Payee Services Representative Payee	Date

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IDENTIFICATION & SOCIAL SECURITY CARDS

Client Name:	**Date:**
State/Tribe Issue Identification Card or Driver's License	
Social Security Card	
VA Card or Other ID	

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Now that you've signed up for Payee Services — what happens next?

You will need to provide Journey Payee Services with the following documents **ASAP**:

- ☐ A lease at a current house or apartment. If you are buying or own your house, a deed or mortgage statement is needed. **Without this documentation, the funds allotted to you by the payee may be limited.**
- ☐ All current bills, with account numbers visible
- ☐ Legal Guardian / POA Paperwork
- ☐ Car/Boat, etc. Registration Forms
- ☐ Signed Release of Information for any persons whom you want the payee to communicate with
- ☐ Bank Statements (If Applicable)
- ☐ You will need to change your billing address for your bills to the following address:
  PO BOX 2690
  Everett, WA 98213

You must go to your local Social Security office and let them know you applied for a payee. They will have you sign Form 4164 (Advance Notification of Representative Payment). This will help the process go smoothly.

Please keep in mind that it may take up to 2 months for Social Security and/or Veterans Affairs to process the paperwork we filled out today.

As always, please feel free to call us if you have any questions.

Thank you,

Journey Housing & Payee Services
7003 Evergreen Way
Everett, WA 98203
425-212-4230
payeeservices@wahoyo.org

Authorized Representative

An Authorized Representative is someone you designate to represent you when you apply for or receive benefits with the Department of Social and Health Services (DSHS) or Health Care Authority (HCA). This individual or organization is authorized to act on your behalf for eligibility purposes. Having an authorized representative is optional; DSHS or HCA cannot withhold benefits if you do not sign this form.

Client Information

NAME	ACES CLIENT ID NUMBER

Authorized Representative Information

NAME	ORGANIZATION AND DEPARTMENT (IF APPLICABLE)	PHONE NUMBER (AREA CODE)
WASHINGTON HOME OF YOUR OWN	REPRESENTATIVE PAYEE	425-212-4230

MAILING ADDRESS	CITY	STATE	ZIP CODE
PO BOX 2690	EVERETT	WA	98213

Program and Duration Information

Which program(s) do you want your authorized representative to act on in your behalf? Check all that apply.

☑ Cash Benefits ☑ Basic Food Benefits ☑ Health Care Coverage ☑ Long-term Care Coverage

How long do you want your authorized representative to act on your behalf?

☐ 90 days ☑ End of certification period (usually one year)

You may withdraw or revoke your request for an authorized representative at any time, verbally or in writing, without any impact on benefits.

Correspondence Information

Please check the level of information or benefits you want your authorized representative to receive.

FOR DEPARTMENT USE ONLY

Rep Type

For Cash, Basic Food, Health Care Coverage or Long-Term Care (check only one of the four boxes below)

☐	Discuss my eligibility for benefits with a DSHS/HCA representative and not receive letters.	**NC**
☐	Receive DSHS/HCA letters and discuss my eligibility for benefits.	**NO**
☐	Receive DSHS/HCA letters, renewal forms and discuss my eligibility for benefits.	**AD**
☑	Receive DSHS/HCA letters, renewal forms, payments, ProviderOne cards and discuss my eligibility for benefits	**NA**

For Health Care Coverage Only (check either box below if applicable)

☑	Hospital representative – receive letters and discuss my eligibility for benefits.	**HO**
☐	Sponsor paying premiums. Sponsors name and address sent to Office of Financial Recovery	**SB**

Client Authorization

AUTHORIZED BY (CLIENT SIGNATURE)	DATE SIGNED	PRINT NAME	PHONE NUMBER (AREA CODE)

NOTE: HIPAA restrictions prevent us from discussing the client's individual health information with the authorized representative unless the representative has power of attorney for the client or the client has signed a DSHS 14-012, Consent form. This includes disclosure of mental health information, HIV/AIDS and STD test results, or treatment and chemical dependency services.

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INSTRUCTIONS

Rep Type – ACES does not limit the Rep Type selections to the codes listed above. If a program requires a Rep Type not listed above or if one of the above codes is selected but is not appropriate for the situation (such as for a group home, protective payee, etc.) enter the appropriate program specific Rep Type on the AREP screen.

Barcode label

14532