

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

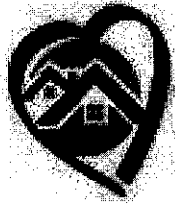


**Journey Housing
& Payee Services**

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!



Journey Housing & Payee Services

Your pathway to stability

EVERETT- MAILING: PO Box 2690, Everett, WA 98213

Phone 425-655-3010 -- Fax 425-303-0493

e-mail: payeeservices@journeyhousingandpayee.org

www.journeyhousingandpayee.org

Thank you for your interest in Journey Housing and Payee Services Payee Program. Please fill out the enclosed intake packet as much as possible. Some items may not pertain to you and do not need to be filled out. In addition, please include any documentation you may have on why you need a Payee.

Once finished, you may return the intake packet in one of the following ways.

In Person:

1520 Broadway Suite 103
Everett, WA 98201

Mail:

PO BOX 2690
Everett, WA 98213

Fax:

425-303-0493

Email:

payeeservices@journeyhousingandpayee.org

Please let us know if you have any questions.

Journey Housing and Payee Services
425-655-3010

*Everett Payee Office
1520 Broadway, Suite 103
(425) 655-3010 - Office
(425) 303-0493 Fax*



INSTRUCTIONS FOR COMPLETING THE CLIENT INTAKE PACKET

- 1) Please complete and sign forms. Incomplete packets will not be processed

- 2) If available, submit copies of identification- such as:
 - State issued driver license or identification card
 - Social Security Card
 - Veterans Administration identification card
 - Tribal ID Card

- 3) If possible, provide a copy of insurance cards, including Medicare, Medicaid

- 4) To assist in developing an accurate budget, please provide copies of the following bills:
 - Rental agreement- it is important we receive this document immediately. Without documentation of rent/mortgage, there can be delays
 - Utilities such as electricity, gas, water, sewer and garbage
 - Any other bills
 - Court fees or fines

- 5) If you have a Guardian or Power of Attorney- Please provide these documents



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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: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorce <input type="checkbox"/> Legally Separated <input type="checkbox"/> Widowed				Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	
If Married, Indicate Spouse's Name and Address (if different):					
Are you a veteran? <input type="checkbox"/> Yes <input type="checkbox"/> No			If Yes, Which Branch of Service:		
SSI/SSA:	VA:	Pension:	Trust:	Wages:	Tribal:
Do you receive your benefits as a dependent of another beneficiary? If so, list the <u>beneficiary's Name & SSN</u> :					
Name of Financial Resource:			Resource Fax # and Contact #:		
Please Indicate The Reason You Are Requesting a Payee: <input type="checkbox"/> Mandated by SSA <input type="checkbox"/> Change in Payee <input type="checkbox"/> Voluntary Enrollment			How Were You Referred to Journey?		
Case Worker's Name/Agency:			Last Visit:		
Address:			E-Mail Address (If Known):		
City:	State:	Zip Code:	Phone Number:		
Guardian/POA Name/Agency:			<input type="checkbox"/> Power of Attorney <input type="checkbox"/> Guardian		
Address:					
City:	State:	Zip Code:	Phone Number:		

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



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Additional Information

[Empty box for additional information]

Disability Type	
<input type="checkbox"/>	<p>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.</p> <p><i>Intellectual Disability, Autism Spectrum Disorder, Prader Willi, Learning Disorders, Down's Syndrome, Etc.</i></p>
<input type="checkbox"/>	<p>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.</p> <p><i>Mood Disorders, Schizophrenia, Anxiety Disorders, Personality Disorders, Sleep/Sexual/Gender/Eating Disorders, ADHD/ADD, Substance Abuse Disorders</i></p>
<input type="checkbox"/>	<p>Physical: A physical impairment, a problem in body function or structure that substantially limits one or more of life's daily activities.</p> <p><i>Cerebral Palsy, COPD, Degenerative Disc Disease, Diabetes, GERD, Hypothyroidism, Migraines, Seizure Disorder/Epilepsy</i></p>
<input type="checkbox"/>	<p>Hearing Impairment: A permanent hearing impairment or deafness, loss or decrease in hearing that is so significant that it negatively affects communication and function.</p> <p><i>Deafness, Hearing Loss</i></p>
<input type="checkbox"/>	<p>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.</p> <p><i>Retinal Detachment, Cataracts, Glaucoma</i></p>
<input type="checkbox"/>	<p>Blind: Complete, total or statutory blindness</p>
<input type="checkbox"/>	<p>Dual Diagnosis: Cognitive disability and a mental illness combination as primary diagnosis. NOT JUST TWO DIFFERENT DISABILITIES</p> <p><i>Intellectual Disability and Obsessive-Compulsive Disorder; Autism and Anxiety Disorder; Dementia and Depression</i></p>



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RENTAL INFORMATION

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

____ (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



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:
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Do You Have a Will? <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> I have no Next of Kin (sign) _____
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Does Your Next of Kin Know Your Wishes? (i.e., Cremation vs Burial) <input type="checkbox"/> Yes <input type="checkbox"/> No	Do You Have a Burial/Cremation Policy? <input type="checkbox"/> Yes <input type="checkbox"/> No
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Which Company is it With?	Current Face Value:	Are You Still Making Payments?
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Name:	Relationship:
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Home Phone:	Work Phone:	E-Mail Address:
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Address:

City:	State:	Zip Code:
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Name:	Relationship:
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Home Phone:	Work Phone:	E-Mail Address:
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Address:

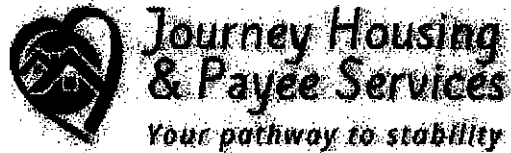
City:	State:	Zip Code:
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NOTE: The next of kin is a person's closest living blood relative. If there is no will, the estate will pass to the next of kin, if there is no surviving spouse, with entitlements passed in the following order: (a) Child or children;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

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

Client Signature

Date



Private Pay

FINANCIAL SERVICE AGREEMENT

This Financial Services agreement is made effective as of _____ by and between Journey Housing and Payee Services and _____.

Beginning on _____ Journey will provide the following services.

- Meet regularly with the beneficiary.
- Establish a budget and involve him/her with the financial decisions.
- Assist client to fill out applications for other services.
- Act as advocate between client and other agencies to ensure he/she received correct benefit amount.
- Journey will pay the following monthly bills on my behalf:
 - ✓ Rent
 - ✓ Utilities
 - ✓ Food
 - ✓ Medical
 - ✓ Credit Cards
 - ✓ Loan Payments
 - ✓ Any remaining funds will go to the client disbursed either daily, weekly, biweekly, or monthly, up to _____ per month.

Please initial each line after you read it.

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

____ 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 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 \$1500/bi-weekly maximum total of \$3000 withdrawal unless prior approval if approved by payee.

____ I understand that I am not allowed to have a personal savings/checking bank account.

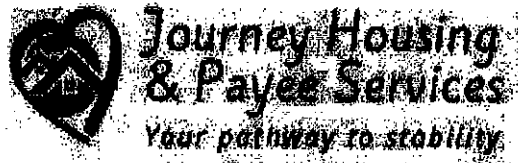


CONDUCT

- ___ I understand that I am only to conduct business with Journey during posted business hours.
- ___ 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 the beneficiary with the same courtesy and respect shown to them.
- ___ I understand that I am limited to call 2 times per day.
- ___ I understand that if I fail to comply with these rules, Journey Housing and Payee Services has the right to terminate Representative Payee services.

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

Client Signature	Printed Name	Date
_____	_____	_____
Legal Guardian/POA Signature	Printed Name	Date
_____	_____	_____
Representative Payee Signature	Printed Name	Date
_____	_____	_____
Witness Signature	Printed Name	Date
_____	_____	_____



IDENTIFICATION & SOCIAL SECURITY CARDS

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