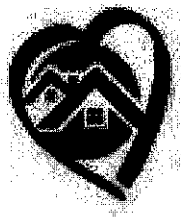
We are excited to announce that Washington Home Of Your Own will now be doing business as...

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

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INSTRUCTIONS FOR COMPLETING THE CLIENT INTAKE PACKET

1) Please complete and Client needs to sign all the forms. Incomplete packets will not be processed

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 have a doctor fill out the enclosed SSA 787 form. (Medical Source Opinion of Patient's Capability to Manage Benefits) and include when returning forms.

3) If available, submit copies of identification- such as:

   - State issued driver license or identification card
   - Social Security Card
   - Veterans Administration identification card

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

5) 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, Social Security benefits can be delayed
   - Utilities such as electricity, gas, water, sewer and garbage
   - Any other bills
   - Court fees or fines

6) 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: ☐ 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:

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 Name/Agency:	Last Visit:

Address:	E-Mail Address (If Known):

City:	State:	Zip Code:	Phone Number:

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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RENTAL INFORMATION

Client Name:			SSN:
Type of Rental: ☐ Room ☐ Apartment ☐ House ☐ Board and Care Facility ☐ Adult Family Home ☐ Other _____			
[redacted]			
Client Name:		Move-in Date:	
Address:		E-Mail Address (If Applicable):	
City:	State:	Zip Code:	Phone Number:
[redacted]			
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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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

Name & Location of Financial Institution:	Account Number(s):
Account Holder's Name:	Account Balance:

Name & Location of Company:	Account Number(s):
Account Holder's Name:	Account Balance:

Type:	Make:	Model:

Name of Company:	Account Number:
Account Holder's Name:	Average Monthly Amount:

Name of Company:	Account Number:
Account Holder's Name:	Average Monthly Amount:

Name of Company:	Account Number:
Account Holder's Name:	Average Monthly Amount:

Name of Company:	Account Number:
Account Holder's Name:	Average Monthly Amount:

Name of Company:	Account Number:
Account Holder's Name:	Average Monthly Amount:

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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:**

Do You Have a Will? ☐ Yes ☐ No	☐ **I have no Next of Kin** (sign) _____

Does Your Next of Kin Know Your Wishes? (i.e., Cremation vs Burial) ☐ Yes ☐ No	**Do You Have a Burial/Cremation Policy?** ☐ Yes ☐ No

Which Company is It With?	**Current Face Value:**	**Are You Still Making Payments?**

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

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.

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

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Additional Information

	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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SSA

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 beneficiary fill out applications for other services.
- Act as advocate between beneficiary and SSA 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 beneficiary disbursed either daily, weekly, biweekly, or monthly.

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 beneficiary ability to pay. The beneficiary 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 I am required to provide receipts and documentation for any single purchase over $100, or as otherwise requested by my payee.

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

____ I understand that if I am employed, it is my responsibility to turn in my paystubs to my payee.

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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
_____	_____	

Revised November 10, 2021

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 Journey Housing and 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

Medical Source Opinion of Patient's Capability to Manage Benefits

	In replying, use this address: SOCIAL SECURITY ADMINISTRATION 3809 BROADWAY EVERETT, WA 98201
	TELEPHONE NUMBER (Including Area Code)
	DATE
	SSA CONTACT

IDENTIFYING INFORMATION (SSA Only)
If different from patient

NAME OF WAGE EARNER OR SELF-EMPLOYED PERSON	SOCIAL SECURITY NUMBER

PATIENT'S NAME

PATIENT'S SOCIAL SECURITY NUMBER	PATIENT'S DATE OF BIRTH

PATIENT'S ADDRESS (Number and Street, City, State, and ZIP Code)

YOUR HELP IS NEEDED

The patient shown above has filed for or is receiving Social Security or Supplemental Security Income benefits. 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 manage the Social Security Administration (SSA) benefits on his or her behalf.

Please Note: This determination affects how benefits are paid and has no bearing on disability determinations. Unfortunately, SSA cannot compensate you for the time it takes to provide this information. Thank you for your help.

WHAT IS A REPRESENTATIVE PAYEE

A representative payee is someone who manages the patient's SSA benefits to make sure the patient's basic 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 managing their SSA benefits or directing others to manage them to meet their basic needs, so we select a representative payee to receive their benefits on their behalf. Examples of impairments that may cause incapability are dementia, brain damage or chronic schizophrenia. However, a person's need for some assistance with financial tasks such as bill paying, etc., does not necessarily mean he or she cannot make decisions concerning basic needs and is incapable of managing his or her own benefits. If the individual is able to direct the management of his or her own benefits, then we will consider the individual capable.

PLEASE COMPLETE THE INFORMATION ON THE REVERSE OF THIS FORM

PATIENT'S NAME

PATIENT'S SOCIAL SECURITY NUMBER | PATIENT'S DATE OF BIRTH

PATIENT'S ADDRESS (Number and Street, City, State, and ZIP Code)

1. Date you first saw the patient _____

2. Date you last saw the patient _____

3. How many times have you seen this patient? _____

4. Are you able to assess the patient's ability to manage or direct the management of funds? ☐ Yes ☐ No

If no, please skip the remaining questions and sign and date the form.

5. What is the basis for your assessment (e.g. observation, medical records, diagnostic tests, patient's self-report, family member's report)?

Note: Please keep in mind in responding to the following questions that the actual performance of the patient, when known, is usually the best indicator of the patient's abilities.

6. Does the patient:

- Have a general understanding of his or her finances (i.e., income, assets, expenses)? ☐ Yes ☐ No ☐ Unknown
- Have sufficient ability to handle a checking/savings account? ☐ Yes ☐ No ☐ Unknown
- Have sufficient ability to pay bills in a timely manner? ☐ Yes ☐ No ☐ Unknown

7. Can the patient successfully manage or direct the management of funds to meet basic needs (e.g. food, clothing, shelter)?

☐ Yes
If "Yes," please provide a brief summary of the findings that led to this conclusion, and complete question 8. Please also sign and date the form.

☐ No
If "No," please provide a brief summary of the findings that led to this conclusion, and complete question 8. Please also sign and date the form.

☐ Unsure
"Unsure," please explain and sign and date the form.

8. Do you expect the patient to be able to manage or direct the management of his or her benefits in the future (e.g. the patient is temporarily unconscious)?

☐ Yes ☐ No

Please explain your answer.

NAME OF MEDICAL SOURCE (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 statement about a material fact in this information, or causes someone else to do so, commits a crime and may be subject to a fine or imprisonment.

SIGNATURE OF MEDICAL SOURCE	DATE

Privacy Act Statement
Collection and Use of Personal Information

Sections 205, 807, and 1631(a) of the Social Security Act, as amended, allow us to collect this information. Furnishing us this information is voluntary. However, failing to provide all or part of the information may prevent us from making a determination regarding the beneficiary's capability or inability to handle his or her own benefits.

We will use the information to determine the beneficiary's need for a representative payee. We may also share your information for the following purposes, called routine uses:

- To Federal, State, or local agencies for administering cash or non-cash income maintenance or health maintenance programs; and
- To contractors and other Federal agencies, as necessary, for the purpose of assisting the Social Security Administration in the efficient administration of its programs.

In addition, we may share this information in accordance with the Privacy Act and other Federal laws. For example, where authorized, we may use and disclose this information in computer matching programs, in which our records are compared with other records to establish or verify a person's eligibility for Federal benefit programs and for repayment of incorrect or delinquent debts under these programs.

A list of additional routine uses is available in our Privacy Act System of Records Notices (SORN) 60-0089, entitled Claims Folders Systems, as published in the Federal Register (FR) on April 1, 2003, at 68 FR 15784, and 60-0222, entitled Master Representative Payee File, as published in the FR on April 22, 2013, at 78 FR 23811. Additional information, and a full listing of all our SORNs, is available on our website at [redacted].

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 20 minutes to read the instructions, gather the facts, and answer the questions. **SEND OR BRING THE COMPLETED FORM TO YOUR LOCAL SOCIAL SECURITY OFFICE. You can find your local Social Security office through SSA's website at [redacted]. Offices are also listed under U.S. Government agencies in your telephone directory or you may call Social Security at 1-800-772-1213 (TTY 1-800-325-0778).** *You may send comments on our time estimate above to: SSA, 6401 Security Blvd, Baltimore, MD 21235-6401.* ***Send only comments relating to our time estimate to this address, not the completed form.***

Journey Housing & Payee Services
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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	

Journey Housing & Payee Services

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AUTHORIZATION FOR RELEASE/DISCLOSURE OF INFORMATION

Client Name:	**SSN:**	**Date of Birth:**
Organization/Person Name:	**Relationship to Client:**	

Authorization for Release of Information

As evidenced by signature below, this authorization will allow Journey Housing & Payee Services (Journey) to act in all matters on my behalf, including, but not limited to, banking, financial, health care, employment, insurance, burial, trust, social services, utilities & housing. I give my consent for your organization to release any and all information regarding me to Journey as my Social Security appointed, or self-selected, Representative Payee. Further, I give consent for Journey to obtain and/or exchange information, negotiate, discuss, and in any other way, communicate with your organization.

If my medical records contain information regarding diagnosis, treatment, vocational rehabilitation records, or referral for mental illness, drug/alcohol abuse, HIV/AIDS or other sexually transmitted diseases, I give my specific authorization for these records to be released to Journey and understand that the federal or state law prohibits re-disclosure, without specific authorization.

Specific Information Authorized *(select one or more as appropriate)*

- ☐ Any and all financial records pertaining to the client and any accounts(s) referenced above
- ☐ Any and all medical records pertaining to client (i.e., hospitalizations, medications, doctor's visits, case narratives, etc.)
- ☐ Any and all employee records pertaining to the client (i.e., paystubs, employment dates, wages, etc.)
- ☐ Any and all other client related records, including client assets (i.e., banking, insurance, burial, trust, etc.)
- ☐ _____

Copy in Lieu of Original

A copy of this authorization shall have the same force and effect as the signed original.

Duration of Authorization

I authorize the periodic use/disclosure as often as necessary to fulfill the purpose identified in this document. This authorization will remain in effect for as long as I am a client with Journey or until revoked by me in writing. The cancellation will not affect any information that was already disclosed. I am signing this authorization of my own free will.

_____ _____

Signature of Client Date

_____ _____

Signature of Legal Guardian/POA Date

Authorized Representative

Washington State Health Care Authority

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.

NAME	ACES CLIENT ID NUMBER

NAME	ORGANIZATION AND DEPARTMENT (IF APPLICABLE)	PHONE NUMBER (AREA CODE)
JOURNEY HOUSING & PAYEE SERVICES	REPRESENTATIVE PAYEE	425-212-4230

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

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.

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

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.
- ☐ Receive DSHS/HCA letters and discuss my eligibility for benefits.
- ☐ Receive DSHS/HCA letters, renewal forms and discuss my eligibility for benefits.
- ☑ Receive DSHS/HCA letters, renewal forms, payments, ProviderOne cards and discuss my eligibility for benefits

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

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

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.

Barcode label

14632