Consumer Credit Counseling Service

2435 Dudley Avenue, P.O. Box 7, Parkersburg, WV 26102
P: (304) 485-3141 F: (304) 485-3286
Working with our Communities since 1971

DATE: ____________ CLIENT #: ____________
REFERRED BY: ____________
CURRENT PAYEE: ____________
CONTACT NAME: ____________
REASON FOR NEW PAYEE: ____________
PHONE: ____________

INTAKE SHEET FOR REPRESENTATIVE PAYEE

Phone:		Date of Birth:	
Claimant's Name:		SS#:	
Spouse's Name:		SS#:	
Client Email:			
Mother's Maiden Name:		Client's City of Birth:	

DEMOGRAPHICS

Level of Education Completed:		Primary Language:	
Hispanic Y/N:		Method of Contact:	
Race:		Referred By:	
Marital Status:		Past Marriage?	
How Long Married?		Divorce Date?	
Military Status:			

LIVING ARRANGEMENTS

Claimant's Address:		How Long?	
Previous Address:		How Long?	

I CURRENTLY LIVE IN:

House:	☐	Room:	☐	Private Home:	☐
Mobile Home:	☐	Commercial:	☐	Apartment:	☐

Do you/spouse own the place you live in?	☐ YES	☐ NO
Do you/spouse rent the place you live in?	☐ YES	☐ NO

I CURRENTLY LIVE WITH:

Alone:	☐	Children:	☐	Eligible Spouse:	☐	Parents:	☐
Essential Person:	☐	Sponsor:	☐	Ineligible Spouse:	☐	Other People:	☐
Total number of people in household:							

Name of Other Household Members	SS#	Receives Public Assistance:
		Type:
		Type:
		Type:
		Type:

LANDLORD INFORMATION:

Name:	Rental Agreement	Monthly Rate
Address:		Phone

FINANCIAL INFORMATION

TYPE OF INCOME	RECEIVED BY	AMOUNT	FREQUENCY

Do you currently receive any income listed below?

Income	Yes	No
Private Pensions/Annuity	Yes ☐	No ☐
Unemployment	Yes ☐	No ☐
Workers Compensation	Yes ☐	No ☐
VA	Yes ☐	No ☐
AFDC or State Assistance	Yes ☐	No ☐
Rental Income	Yes ☐	No ☐
Alimony/Child Support	Yes ☐	No ☐
Dividends/Royalties	Yes ☐	No ☐
Interest in Bank Accounts	Yes ☐	No ☐
Money from Trust Funds	Yes ☐	No ☐
Money from Organizations	Yes ☐	No ☐
Do you currently receive food stamps?	Yes ☐	No ☐
Have you filed for food stamps in the past 90 days?	Yes ☐	No ☐

EXPENSE	AMOUNT
Food	$
Mortgage/Rent	
Insurance-Property	
Gas	
Electric	
Water/Sewer	
Trash	
Payee Fee	
Other	
Other	
Other	
Other	
TOTAL:	$

EARNED INCOME

Do You currently work? ☐ Yes ☐ No

Have you ever worked? ☐ Yes ☐ No

How Long? ________________

Have you or your spouse worked or expect to work in the next 14 months? Yes ☐ No ☐

Name of Worker	Employer Name & Address	Gross Wages

RESOURCES

Cash with you?	Yes ☐ No ☐	
Checking Accounts	Yes ☐ No ☐	
Credit Union Accounts	Yes ☐ No ☐	
IOU's	Yes ☐ No ☐	
Stocks/Bonds	Yes ☐ No ☐	
Other items that can be sold/cashed?	Yes ☐ No ☐	

NAME OF EACH ITEM	OWNERSHIP OF ITEM	VALUE

Do you/spouse own any headstones, markers, cemetery lots, crypts, urns, or mausoleums?

Yes ☐ No ☐

If Yes:

NAME OF OWNER	FOR WHOSE BURIAL	RELATIONSHIP	DESCRIPTION/VALUE

Do you/spouse own or are buying any life insurance policies? Yes No ☐

If Yes:

NAME OF OWNER	NAME OF INSURED	INSURANCE COMPANY	INSURANCE ADDRESS

POLICY NUMBER	TOTAL FACE VALUE	CASH SURRENDER VALUE	DATE OF PURCHASE

Do you/spouse own a vehicle? Yes ☐ No ☐

MAKE	MODEL	YEAR	APPRAISED VALUE

LOAN COMPANY	ADDRESS	ACCOUNT #
INSURANCE COMPANY	ADDRESS	POLICY DATE DUE

MEDICAL INFORMATION

Do You Have a Legal Guardian? Yes ☐ No ☐

If Yes: Date of Appointed Guardian:

Guardian's Name:	Guardian's Address:	Guardian's Phone Number:

Have you spent more than 30 days in a hospital/institution in the past year? Yes ☐ No ☐

If Yes:

Name of Facility: ______________________

Date Entered: ____________ Date Discharged: ____________

Are you currently under any medical/psychological treatment? Yes ☐ No ☐

If Yes:

Name of Facility ______________________

Date of Last Visit ______________________

Name of Facility ______________________

Date of Last Visit ______________________

Are you currently receiving Case Management from any agency? Yes ☐ No ☐

Case Manger's Name:	Agency:	Phone:

What is your disabling condition for which you are receiving disability benefits?

____

____

Date your condition was diagnosed: ____________

Do you receive Medicaid Card? Yes ☐ No ☐

ADDITIONAL INFORMATION

Please provide original or copies of the following documents:

☐ Birth Certificate	☐ Marriage Certificate(if applicable)	☐ State Issued ID/Driver's Lic.
☐ Social Security Card	☐ Divorce Certificate (if applicable)	☐ Current Rental Lease or Mortgage Statement

REMARKS:

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AUTHORIZATION OF RELEASE OF INFORMATION

I, the undersigned, hereby authorize Consumer Credit Counseling Services of the Mid-Ohio Valley (CCCS), Representative Payee for Social Security, SSI, and VA benefits, to consult with, release to, or receive from:

- All Landlords
- Creditors
- Utility Companies
- All regulatory and funding sources and services providers, (case managers, etc).

The information necessary for the maintenance of the client's account for the purpose of the Representative Payee Program for the period and length of the program.

____
Date

____
Client Signature

____
Client's Social Security Number

____
Representative Payee

If you are a responsible party with the authority to sign on behalf of the client, please provide a copy of legal documentation with this release stating such.

THIS PAGE MUST BE PRINTED AND SIGNED (ELECTRONIC SIGNATURE NOT ACCEPTABLE)

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 ______________________________ 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 <u>only</u> 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)
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