Compassionate Hearts Financial Services, Inc.

Specializing in Representative Payee Services

Where Everyone's Treated Like Family

Client Information

Name: _____ Insurance type:_____ Number: _____

D.O.B:_____SS#:_____ Gender: _____

Lives with:_____Street Address: _____ City/State/Zip:_____

Mailing Address:_____City/State/Zip:_____

Name(s) of person(s) living with:

NAME	RELATIONSHIP

Home/Cell phone:_____ Work phone:_____

Emergency contact:_____ Phone:_____

Street address:_____ City/State/Zip:_____

Income: How much do you receive for each monthly benefit or work? Please fill in all that apply:

Social Security:_____SSI:_____SSDI:_____Work:_____Food Stamps:_____

Currently have representative payee:_____ If yes

Name of current payee:_____Phone:_____

Address:_____ City/State/Zip:_____

Have court appointed legal guardian?_____If yes, name:_____

Title:_____Phone:_____Address:_____

Date of Appointment:_____Reason guardian assigned:_____

_____

Reason representative payee being requested:_____

_____

_____

Referral source:

Name/title:_____ Phone:_____

2605 72nd Avenue East, Suite 583
Ellenton, FL 34222
Phone/Fax 941-803-4215

Compassionate Hearts Financial Services, Inc.

Specializing in Representative Payee Services

Where Everyone's Treated Like Family

Client name:_____ last four digits of social Security number:_____

Address:_____ Date of Birth:_____

_____ Phone number:_____

I, or my advocate, have discussed my needs with a representative of Compassionate Hearts Financial Services. I agree to have Compassionate Hearts Financial Services, Inc. serve as my representative payee for my monthly SSDI, SSI or social security benefit. In return for a fee, regulated by the Social Security Administration, I understand Compassionate Hearts Financial Services, Inc. will provide the following services:

- Deposit, monitor and review all federal benefits
- Ensure I remain in compliance with all federally mandated Social Security Administration regulations
- Develop and maintain budget plans to meet my financial obligations and goals
- Process payments and store records of my expenses
- Maintain up to date records with the Social Security Administration
- Reconcile my financial records at least once a month
- Provide annual reporting to the Social Security Administration
- Upon request, provide reports outlining my account activity and balances

category	Amount	Payable to	Mailing Address
Rent			
Electric			
Water			
Phone			
Personal			
Cable			
Other			

I agree to:

- Pay Compassionate Hearts Financial Services, Inc. monthly fee
- Treat staff with respect and courtesy
- Submit receipts for purchases I make with the funds I receive (when required)
- Report all wages earned to my Compassionate Hearts Financial Services representative

I understand that if I fail to comply with these rules, Compassionate Hearts Financial Services may refuse to continue to serve as my representative payee.

_____ Date_____

Beneficiary/Guardian Signature

_____ Date_____

Witness Signature

2605 72nd Avenue East, Suite 583
Ellenton, FL 34222
Phone/Fax 941-803-4215

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 **Compassionate Hearts Financial Services, Inc.** 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

Witness's 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)