



Name: _____ SSN: _____

Address _____
(Street) (City) (State) (Zip)

Phone Number _____ Birth date _____

Gender: Male Female Ethnicity: Hispanic Non-Hispanic Not Known

Race: Caucasian African-American Asian American Indian Hispanic
2 or more Other Unknown

Marital status: _____

Mother's maiden name: _____ Father's name: _____

Where were you born?: _____
City State

The above information is security questions for Social Security. We MUST have this information to call in your application

Beginning date of disability (not application date to SSA) _____

Diagnosis: _____

Medicaid # _____ Medicare # _____

Income: SSDI \$ _____ SSI \$ _____ VA \$ _____ Vision \$ _____ Other _____ \$ _____

Are you working? Yes No Name of Employer: _____ \$ _____ monthly

Assets: Do you have any assets (i.e.: trust, checking/savings acct., car, or real estate)? Yes No

If yes, explain: _____

Do you have a prepaid burial/funeral plan? Yes No If yes, what location? _____

Do you receive Food Stamps? Yes _____ No _____ If yes, amount received _____

Landlords name: _____ Phone _____ Rent _____

Address _____
(Street) (City) (State) (Zip)

If less than a year (previous address) _____ Move date _____ Rent _____

Property Type: Apartment House Hotel Mobile Home Duplex or similar Other , please explain other: _____

Please circle those that apply:

- Is the applicant homeless? Yes No
- Does the applicant live alone? Yes No
- Does the applicant live in own home? Yes No
- Does the applicant live with a relative? Yes No
- Does the applicant live with someone else? Yes No
- Does the applicant live in a board and care facility? Yes No
- Does the applicant live in a nursing home? Yes No

Are you currently working? Yes No

If yes, where: _____

Do you want Breakthrough to assist with managing your payroll? Yes No

If no, are you interested in employment? Yes No

Do you use the public transportation system? If so, what passes do you purchase and approximately how often?

Will the applicant come in once per week. Yes No

Other arrangements: Explain _____

Does the applicant have a criminal history? Yes No If so, please explain? _____

Have you ever been arrested for anything more than a traffic violation? Yes No If yes, please explain: _____

Case Manager: _____ Agency _____

Agency Address _____ Phone: _____ Ext. _____

Doctor: _____ Last seen _____ Phone _____

Counselor: _____ Last seen _____ Phone _____

Psychiatrist: _____ Last seen _____ Phone _____

Does the applicant have a legal guardian? Yes No If yes, who is it: _____

*****If "yes" you need to include a certified copy of your guardianship papers*****

Guardian/Conservator: _____ Phone _____

Address _____
(Street) (City) (State) (Zip)

Did the applicant have a payee in the past? Yes No If yes, provide name and address below:

Name _____ Phone _____

Address _____
(Street) (City) (State) (Zip)

Children	Name	DOB	Address

In case of emergency contact:

Name _____ Phone _____

Address _____
(street) (city) (state) (zip)

Relationship: _____

Please list names, address, phone numbers and relationships of any other relatives or close friends who have provided support to the applicant in the past.

Name	Address	Phone	Relationship

*****Please provide the reason you are in need of Payee services. If there is any other information relating to the urgency of receiving Payee services through Breakthrough, please provide this information:**

Signature: _____ Date: _____

Breakthrough | Episcopal Social Services
P.O. Box 670, Wichita, KS 67201
(316) 269-4160 ♦ Fax (316) 269-3550

RELEASE OF INFORMATION Representative Payee Program

I, the undersigned do hereby request and authorize the release of information requested below from the records of:

I, _____ DOB _____ SSN _____

By Initialing the spaces below, I specifically authorize the disclosure and/or exchange of information and/or permission to make changes to account services with the following individuals or agencies;

INFORMATION/RECORDS NEEDED:

_____ Physicians, Psychiatrists, and/or Counselors
_____ Diagnosis _____ Medication List _____ Behavior
_____ *Case Managers, Community Support agencies, and/or Attendant Care Workers
_____ *Utility/Vendors (including, but not limited to; Westar, Kansas Gas Service, Public Works,
AT&T, insurance agents, any other provider/bill collection agency, etc.)
_____ *Social Security Administration and/or Department of Veteran's Affairs
_____ Specific names of individuals that provide support:

Items marked with * are mandatory for program participation.

The purpose of exchange of information between the above individuals and/or agencies is to serve you in an effective and efficient manner while receiving services from the Representative Payee Program.

This release is effective during your service period with Episcopal Social Services. This release will remain effective until 30 days after termination of services.

(42 C. F. R. Part 2: Prohibition of Re-disclosure: The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.)

I understand that **I may revoke this consent at any time by providing written notification** of my intent to do so to Episcopal Social Services providers. I understand that this does not apply to information that has already been disclosed.

Signature of Applicant or Parent/Guardian Date

Witness Date



Name: _____ Phone: _____

Circle the following items you have and list the provider (if different) and average payment.

Rent: _____ (Landlord information on Initial Application)

Gas Kansas Gas \$ _____ Cable Cox Communication \$ _____

Electric Westar Energy \$ _____ Other _____ \$ _____

Cell Phone _____ \$ _____ Phone _____ \$ _____

List the other obligations you have i.e., Pharmacies, Physicians, Dentist, Insurance, Car Payments, Storage, debts, overdue bills, etc.

Provider: _____ Average Monthly payment: _____

Contact: _____ Telephone: _____

Address: _____

(street) (city) (state) (zip)

Provider: _____ Average Monthly payment: _____

Contact: _____ Telephone: _____

Address: _____

(street) (city) (state) (zip)

Provider: _____ Average Monthly payment: _____

Contact: _____ Telephone: _____

Address: _____

(street) (city) (state) (zip)

Provider: _____ Average Monthly payment: _____

Contact: _____ Telephone: _____

Address: _____

(street) (city) (state) (zip)

Provider: _____ Average Monthly payment: _____

Contact: _____ Telephone: _____

Address: _____

(street) (city) (state) (zip)

Provider: _____ Average Monthly payment: _____

Contact: _____ Telephone: _____

Address: _____

(street) (city) (state) (zip)

Signature: _____ Date: _____

WHAT TO EXPECT WHEN YOU BECOME A BENEFICIARY
Through BREAKTHROUGH

1. We will open a checking account to be used for your funds only. When we meet, it will be you or you and case manager or guardian. This will be at the Payee's discretion.
2. You will be assigned a specific day of the week to visit with your Representative Payee. Your account must only be serviced on that day and that day ONLY. (This includes telephone calls unless it is an *emergency*.) If you cannot come in on your assigned day, we can mail your check to you.
3. Sign in at the front desk when you arrive and you will be seen on a first-come-first-served basis.
4. The fee for this program is set by Social Security and adjusted annually. The current fee is \$ _____ or 10% of your monthly income whichever is lesser, *or* in the case of clients with a drug and alcohol diagnosis (DAA), the fee is \$ _____ or 10% of your monthly income. **A balance of \$20 must remain in your account at all times to keep the bank account open.**
5. If a beneficiary is found to have been drinking or taking illegal drugs prior to their visit they will be asked to leave the property and return next week. If a beneficiary is suspected of conducting illegal activities on the property they will be in jeopardy of being dismissed from the program.
6. If at any time you are living in a motel, homeless, or in a shelter, spending will be reduced to a maximum of \$20 per week. The remainder of the money will be saved each month for permanent housing needs, as this is the first item ESS is obligated to use benefits for. We will make sure that your savings do not exceed the amount allowed by SSA.
7. At all times you must be respectful to all volunteers and staff regardless of your situation. If your behavior is inappropriate, it is grounds for suspension or dismissal. If at any time you demonstrate that you cannot work with us within these guidelines, we have the right to notify Social Security and/or the VA, and you must get another payee.
8. We have three internal policies regarding your money. We do not pay bail bondsmen. We do not write undesignated checks for over \$100 to the client without staff approval. Any extra money outside of weekly spending is issued quarterly, with payments in March, June, September, and December.
9. When you receive a personal needs check, you are required to provide receipts or sign a personal needs receipt stating what you are using the funds for. This is a Social Security Administration requirement.
10. In an effort to have bills paid on time and avoid late charges, once ESS has been appointed by Social Security Administration and/or the VA, all bills need to be mailed directly to Episcopal Social Services from the billing source. **If bills are not mailed directly to ESS, spending will be a maximum \$20 weekly, to ensure that funds are available to pay bills.**
11. Breakthrough is obligated by Social Security Administration and/or the Veterans Administration to use your benefits for (1) rent, (2) utilities, (3) food and (4) medical, primarily. If there is money remaining after these obligations are met, we will help you budget for other expenses, ie. clothing, dental services or long term debt. THESE 4 ITEMS MUST BE ATTENDED TO FIRST: Rent, Utilities, Food, and Medical.

My day to see my Representative Payee is _____

I HAVE READ THE ABOVE EXPECTATIONS and AGREE TO TERMS FOR SERVICES:

Beneficiary's Signature

Date

What an Organizational Representative Payee does for you:

Your payee receives your monthly benefits and must use the money to pay for your current needs, including:

- Housing and utilities;
- Food;
- Medical and dental expenses;
- Personal care items;
- Clothing; and
- Rehabilitation expenses (if you are disabled).

After those expenses are paid, your payee can use the rest of the money to pay any past-due bills you may have, give you spending money, support your dependents or provide entertainment for you. If there is money left over, your payee should save it for you.

Your payee must keep accurate records of your money and how it is spent. Your payee also must regularly report the information to Social Security.

If you live in an institution, such as a nursing home or hospital, your payee should pay the cost of your care and provide money for your personal needs.

Tell your Representative Payee if you:

- Get a job or stop working;
- Move;
- Get married;
- Take a trip outside the United States;
- Go to jail or prison;
- Are admitted to a hospital; or
- Are no longer disabled, if your benefits are based on a disability.
- Get money from another source;
- Apply for help from a welfare department or other government agency; and
- Have any saved monies.

If your payee does not report any of the above actions to Social Security, you may be paid too much money. In that case, you may have to return the money you were not due and your payments may stop. If we determine that either you or your payee intentionally withheld information in order to continue to receive payments, you or your payee may be prosecuted criminally.

I have read and understand the above information:

Signature: _____ Date: _____



NEW CLIENT GENERAL HOUSEHOLD INFORMATION

To expedite the application process and provide Social Security with answers to questions they may have, please complete and submit with completed application form. Please list **ALL** persons currently living in the household. Please provide an answer to all the questions listed or write N/A for any information that does not apply to your situation.

➤ NAME:

➤ DATE OF BIRTH:

➤ RELATIONSHIP TO CLIENT:

➤ SOCIAL SECURITY NUMBER & DATE OF BIRTH:

➤ SOURCE OF INCOME:

➤ NAME:

➤ DATE OF BIRTH:

➤ RELATIONSHIP TO CLIENT:

➤ SOCIAL SECURITY NUMBER & DATE OF BIRTH:

➤ SOURCE OF INCOME:

➤ NAME:

➤ DATE OF BIRTH:

➤ RELATIONSHIP TO CLIENT:

➤ SOCIAL SECURITY NUMBER & DATE OF BIRTH:

➤ SOURCE OF INCOME:

Signature: _____

Date: _____

Breakthrough | Episcopal Social Services Roommate Agreement

Housing Information

Type of Housing:

Address:

City:

State:

Zip Code:

Roommate Information

Number of roommates:

First Roommate's name & phone number:

Second Roommate's name & phone number:

Rental Agreement

Is there a written lease agreement with the landlord?

When did the lease commence?

When does the lease agreement end?

Name of Landlord:

Address:

City:

State:

Zip Code:

Phone Number:

Utility Information

Will the cost of all utilities be included in the rent?

Will the cost of food be included in the rent?

Check all services for which the roommates will be responsible and indicate how they will be split:

Gas

Electric

Water

Telephone

Cable

Other

**** All housing payments are made directly to the landlord/owner of title****

Signatures of 1st roommate:

Signatures of 2nd roommate:

Date: