COMMUNITY ENGAGED
PAYEE SUPPORT

Welcome to CEPS!

Please complete the enclosed forms to begin your intake process. All items must be completed, signed, and returned to us by fax, email, or mail.

Social Security will not process your application unless ALL forms are completed. Missing forms or information will delay your payments. Please contact us if you have any questions regarding any of the forms, we are here to help.

Once CEPS receives your packet, we will contact you to review the intake. Please make sure we have updated contact information. We will also let you know when you can expect to begin receiving your benefits and answer any questions.

Address: 3111 Fulton Ave, Ste 101 Sacramento, CA 95821

Phone: 916-348-1890 **Fax:** 916-348-1894

Email: info@CEPSonline.org

Advocate:	**Alpha**	**Phone Ext.**
Amanda	A-C	Ext. 1
Natalie	D-Ha	Ext. 2
Hanna	He-L	Ext. 4
Shay	M-O	Ext. 5
Martha	P-S	Ext. 6
Michelle	T-Z	Ext. 7
Jocelyn	ALTA/VA/ Minors	Ext. 8

We're happy to help, call us with any questions.

Your CEPS Team

CEPS
Client Intake Sheet

Client Name _____

SSN _____ Mothers Maiden Name _____

Birth Date _____ Birthplace _____

Client Address _____

City _____ State _____ Zip _____

Phone _____ Message Phone _____

Gender: (circle one) Male Female Non-Binary Transgender

Ethnicity:

☐ Asian	☐ Black/Afro-American
☐ White/Caucasian	☐ Hispanic/Latino
☐ Native	☐ Hawaiian/Pacific
☐ Am/Alaskan	☐ Islander Unknown

Landlords Name _____

Address _____

City _____ State _____ Zip _____

Phone _____ Message Phone _____

Rent Amount $ _____ Living / Arrangement _____

Do you utilize other types of agencies for support? Yes_____ No _____
(Exp: Alta, Telecare, chore workers, ECT…)

Agency Name _____ Workers Name _____

Address _____

City _____ State _____ Zip _____

Phone _____ Ext. _____ Cell Num _____

Fax Number _____ Email _____

Employee Intl.:_____ Update:_____

Emergency Contact

Emergency Contact person _____

Relation _____

Address _____

City _____ State _____ Zip _____

Phone _____ Message Phone _____

Emergency Contact person _____

Relation _____

Address _____

City _____ State _____ Zip _____

Phone _____ Message Phone _____

Social Security Information

Is this a new claim? Yes_____ No _____

Who is the former payee? _____

What Social Security Office is your claim from? _____

Who is your Social Security worker? _____

Benefit Type: Title II (SSA) _____ Title XVI (SSI)_____ or Concurrent (Both)_____

Any other information you feel would help us aid you with your benefits?

_____

_____

_____

SSI/SSA Information

Do you receive or expect to receive:

A. Private pension and/or annuities (other than Social Security, SSI, or food stamps)? Yes _____ No _____

B. Unemployment or workers compensation? Yes _____ No _____

C. AFDC or State or local assistance based on need (Such as Food Stamps)? Yes _____ No _____

D. Veterans Administration benefits (based on need, not based on need, or education)? Yes _____ No _____

E. Rental/lease income? Yes _____ No _____

F. Alimony or child support? Yes _____ No _____

G. Dividends or royalties? Yes _____ No _____

H. Interest earned on money in bank accounts (including interest on checking accounts)? Yes _____ No _____

I. Money from a trust? Yes _____ No _____

J. Money from any other person or organization? Yes _____ No _____

K. Are you currently employed? Yes _____ No _____

Do you (or your spouse living with you) own:

A. Cash (with you, at home, in a safe deposit box)? Yes _____ No _____

B. Checking accounts? Yes _____ No _____

C. Savings accounts? Yes _____ No _____

D. Credit union accounts? Yes _____ No _____

E. Christmas club accounts? Yes _____ No _____

F. Savings certificates/ certificates of deposit? Yes _____ No _____

G. Promissory notes or IOU's? Yes _____ No _____

H. Stocks or bonds? Yes _____ No _____

I. Other items that can be cashed in or sold? Yes _____ No _____

If yes to any of the previous questions, please describe:

_____

_____

_____

_____

SSI/SSA Information Continued

Is your name on the title of any life insurance policies? Yes _____No _____

Is your name on the title of any vehicles (a car, truck, boat, camper, motorcycle, ect.)? Yes _____No ____

Do you (or your spouse living with you) own or are you buying any real estate (land or buildings or other structures on the land)? Include property outside the U.S., inherited property, and life estates. Do not include your home. Yes _____No _____

Do you (or your spouse living with you) own any of the following items (answer **"yes"** if your name or your spouse's name appears alone or with any other person as the owner or part owner of any of these items):

A. Other household or personal items not already mentioned worth more than $500? Yes _____No ____

B. Other equipment (business or nonbusiness) or property of any kind (not already included on this form)? Yes _____No _____

C. Do you (or your spouse living with you) own any headstones or markers, cemetery lots, crypts, urns, mausoleums, or other repositories for burial? Yes _____No _____

D. Do you (or your spouse living with you) have any money or assets, such as, burial contracts, trusts, insurance policies, agreements, or anything else you intend to use for your burial expenses? Yes _____No _____

E. Have you (or your spouse living with you) had any changes in health insurance coverage or other insurance that pays for medical bills? (Do not include Medicare, but do include insurance such as accident, automobile, or causality if it covers medical bills for any reason.)

Yes _____No ____

Other information

A. Have you been accused or convicted of a felony or attempted to commit a felony?
If yes, in which State: ____, or Country: _____ Yes _____No _____

B. Have you fled prosecution for that crime or fled to avoid custody or confinement after conviction? Yes _____No _____

C. Are you on parole or on probation under Federal or State law?
If State law, which State: ____. Yes _____No _____

D. Have you violated a condition of your parole or probation? Yes _____No _____

E. Are you currently married, or have you been Married (Dates)? Yes _____No _____

F. Do you have Children (Name, DOB, and SSN)? Yes _____No _____

If yes to any of the previous questions, please describe:

_____

_____

_____

Demographics

A. Physical Limitations… .....Yes_____No_____
Comments:_____

B. Probation..... Yes_____No_____
Comments:_____

Probation Start_____ Probation End_____ Release_____

C. Parole..... Yes_____No_____
Comments:_____

Parole Start_____ Parole End_____ Release_____

D. Mental Health Provider..... Yes_____No_____
Comments:_____

E. Medication..... Yes_____No_____
Comments:_____

F. Domestic Violence .....Yes_____No_____

G. Medi-Cal..... Yes_____No_____

H. Medi-Care ..... Yes_____No_____

I. Prescription Plan….....Yes_____No_____
Comments:_____

Resources/Referrals_____

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

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 **CEPS** to be my representative payee.

My Right to Appeal

I understand that I have the right 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 (No. and Street, City, State and Zip Code)	Address (No. and Street, City State and Zip Code)

CEPS Agreement for Representative Payeeship

I hereby authorize CEPS (Community Engaged Payee Support) to become payee for my SSA/SSI benefits I am eligible to receive or have received. I fully understand that CEPS will administer these funds.

I am aware that the fee for these services is fifty-four dollars ($54.00) per month and will adjust with the Federal cost of living adjustment (COLA).

I agree to inform a CEPS representative within thirty days if I am going to change my representative payee to make arrangements for my funds. This may result in payment being delayed.

Client Signature Date

CEPS Representative Date

CEPS Operation Procedures

Client Name: _____ SSN: _____

1. Business hours are posted each month on the CEPS client calendar. We are closed on the last working day of the month and the third Wednesday of the month for a team meeting. All Federal Holidays will be observed.
2. When CEPS becomes your representative payee, your benefits will be direct deposited into our trust account on your behalf. Information regarding your personal account is available for your review.
3. Clients that are required by Social Security to have a Representative Payee will be charged a CEPS fee which is limited to $54 or 10% of the benefit amount per month, whichever is lower. SSA sets this fee and will notify you of COLA changes.
4. No money "cash" is kept on the premises or distributed from our office. All payments are disbursed by mail via check and pay card, or direct deposit only.
5. All check requests will require one business day (24 hour) advance notice prior to 1pm, weekends and holidays do not count. Requests may be made by telephone or mail. For payment on the first or third of any month we require a five-day notification prior to the first to ensure accuracy.
6. Please notify us immediately if a check is lost or stolen. If a check is lost or stolen our staff will make every effort to retrieve your funds. However, the responsibility is yours. You may place a stop payment. If you choose to do so, your account will be charged the $20 bank fee. Your funds will be released in 30 days or as soon as we receive confirmation the check has been stopped.
7. Our office does not accept collect calls.
8. Our staff will open any mail received at our office on your behalf.
9. We reserve the right to refuse you service if you are intoxicated or under the influence of any controlled substance. Our staff will use their discretion.
10. In case of overpayment you agree to return the funds.
11. If you are in jail or in prison you must notify us. If you are entitled to funds, we can mail a money order to you.
12. It is your responsibility to provide us with the information needed to create a budget for you, this includes your rental agreement, utility statements, and receipts for expenses.
13. It is your responsibility to inform us if you move, if you leave the US, if your household changes (people move in or out), if you get married or divorced, receive money, earn an income, enter a hospital or treatment center, become incarcerated (jail or prison), or enter another institution.
14. If you have an unsatisfied felony warrant or are in violation of a condition of your probation or parole your benefits may stop.
15. You may update your assignment of beneficiary in writing at any time.

Client agrees to fully release CEPS (including, without limitation, its agents, officers, directors, employees, owners, successors, and assigns) from any and all liability in any way whatsoever arising from or related to CEPS's management and/or distribution of benefit payments. This includes, but is not limited to, any and all liability resulting from any acts or omissions of CEPS and/or its agents. Client further agrees that he/she and/or his/her estate shall indemnify, defend and hold CEPS (including, without limitation, its agents, officers, directors, employees, owners, successors and assigns) harmless from any and all liability for any loss, cost, damage, claim, lawsuit, award, penalty, assessment, judgment and/or injury to persons or property in any way whatsoever arising from or related to CEPS's management and distribution of benefit payments. This includes, but is not limited to, indemnification for all consequential, special, general and/or punitive damages, whether or not resulting from the acts and/or omissions of CEPS and/or its agents.

Client Signature: _____ Date: _____

CEPS Assignment of Beneficiary

Client's name:_____ Date: _____

Social Security number: _____ Birthdate (mm/dd/yyyy): _____
Address: _____
City, State, ZIP Code: _____
Phone number: _____ Email address: _____

CHOOSE BELOW:

1. I hereby designate the person(s) named below as beneficiary(ies) of the remaining amount in my account with Community Engaged Payee Support (CEPS), revoking any previous beneficiary designation.

☐ **Primary Beneficiary Designation**

Full name: _____
(Last, First, Middle Initial)
Relationship: _____
Date of birth: _____
Address _____
(Street, City, State, Zip)
Phone #: _____

☐ **Contingent Beneficiary Designation**

Full name: _____
(Last, First, Middle Initial)
Relationship: _____
Date of birth: _____
Address: _____
(Street, City, State, Zip)
Phone #: _____

2. Rather than designating individuals as the beneficiary(ies) of the remaining amount in my account with Community Engaged Payee Support (CEPS), I hereby designate the following organization to receive the remaining amount in my account upon my demise:

☐ **Non-Profit and/or Other Entity or Organization Beneficiary Designation**

Entity/Organization Name: _____ Website: _____
Address: _____ Phone #: _____
(Street, City, State, Zip)

☐ **I chose not to designate a beneficiary** **Initial** _____

GUIDELINES FOR DESIGNATION OF BENEFICIARIES

BY FAILING TO DESIGNATE ANY BENEFICIARY ABOVE, BY SIGNING BELOW, I ACKNOWLEDGE, CONSENT TO AND ALLOW CEPS TO DISTRIBUTE THE REMAINING BALANCE OF MY ACCOUNT UPON MY DEMISE TO A NON-PROFIT OF CEPS CHOICE. I LIKEWISE AGREE THAT MY ESTATE AND I RELEASE CEPS OF ANY AND ALL LIABILITY WHATSOEVER IN ANY WAY ARISING FROM ITS DISTRIBUTION OF SUCH FUNDS AS A RESULT OF MY FAILURE TO DESIGNATE ANY BENEFICIARY TO RECEIVE SUCH FUNDS AND AGREE TO DEFEND, INDEMNIFY AND HOLD CEPS (INCLUDING ITS AGENTS, OFFICERS, DIRECTORS, EMPLOYEES, OWNERS, SUCCESSORS AND ASSIGNS) HARMLESS FROM ANY AND ALL THIRD PARTY CLAIMS, ACTIONS, LAWSUITS, JUDGMENTS AND/OR DAMAGES OR LIABILITY RELATING THERETO.

General Please be sure to include the beneficiary's full name, social security number and relationship to you. Providing this information can help expedite the claim process by making it easier to locate and verify beneficiaries.
Minors While you may designate minors as beneficiaries, please note that claim payments may be delayed due to special issues raised by these designations. In the event the proceeds may be paid to a duly appointed guardian of the child's estate. You may wish to consult with an attorney when drafting your beneficiary designation.
Life Status Changes It is recommended that you review your beneficiary designation when various life status events occur, such as marriage, divorce, or birth of a child.
No Beneficiary Please note that if you do not elect a beneficiary, any remaining balance in your account with CEPS will be donated to a non-profit of CEPS choice and you acknowledge, agree and consent to such distribution as set forth above.

AGAIN, BY SIGNING BELOW, YOU AGREE THAT YOUR FAILURE TO DESIGNATE A BENEFICIARY TO RECEIVE REMAING FUNDS IN YOUR ACCOUNT UPON YOUR DEMISE SHALL EXPRESSLY GRANT CEPS THE AUTHORITY TO DISTRIBUTE SUCH FUNDS TO A NON-PROFIT ENTITY OF ITS CHOICE AND YOU EXPRESSLY WAIVE ANY AND ALL CLAIMS WHATSOEVER AGAINST CEPS AND ITS AGENTS, OFFICERS, DIRECTORS, OWNERS, EMPLOYEES, SUCCESSORS AND ASSIGNS FOR SUCH CONDUCT AS WELL AS AGREE TO INDEMNIFY, DEFEND AND HOLD CEPS HARMLESS FROM ANY CLAIMS AND/OR LIABILITY ARSING THEREROM.

Client Signature: _____ Date: _____

If signed with an x: Witness Name:_____ Witness Signature: _____

AUTHORIZATION TO OBTAIN OR RELEASE PROTECTED FINANCIAL INFORMATION

Client Name _____SSN _____

I, _____, hereby consent and authorize. CEPS and _____to disclose benefit eligibility payment information about me for use in applying for any Social Security benefits or Supplemental Security benefits, I may be eligible to receive. As well as for planning and providing services for me.

To ____OBTAIN and/or ____RELEASE protected health/financial information concerning professional services received by myself or my minor child to the following:

CEPS-Sacramento
3111 Fulton Ave
Sacramento, CA 95821

This authorization is subject at any time in writing, and unless otherwise specified herein will expire one year from the signature date.

Specific Information to be disclosed (check at least one):

___Recommendations for Budget
___Current Monthly Expenses
___Statement of Progress
___Treatment Summaries
___Summary Diagnostic Information
___Medication
___Psychological Evaluations
___Psychotherapy Notes
___Discharge

__Other:_____
_____
_____
_____

_____
I understand that information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient of my health information and no longer protected by the HIPAA Privacy Rule. I understand all of the aforementioned, and with informed consent and of my own free will, authorize disclosure of protected health information. Please forward any requested information to:
CEPS 529 14th St, Modesto, CA 95354.

Signed: _____Date:_____

Witness: _____Date:_____

If Client is Homeless- Fill out the attached forms

- Application for California Restaurant Meals Allowance

- Statement of Claimant or other person
  Sign where marked and complete all required answers

APPLICATION FOR CALIFORNIA RESTAURANT MEALS ALLOWANCE

(Application for Optional supplemental Variation C – Independent Living Arrangement Without Cooking Facilities)

NAME *(Of Applicant/Recipient)*	**SSN** *(Of Applicant/Recipient)*

I/We am/are applying for the Restaurant Meals Allowance and understand that to be eligible, the following requirements must be met:

1) I/we do not receive meals as a part of my/our living arrangements, AND

2) Beginning ___/___/___ one of the following conditions exits:
(*Enter date)*

(*Check one or more blocks that apply.)*

☐ I/we do not have access to a working refrigerator or icebox.

☐ My/our cooking facilities are inadequate because I/we do not have access to: a working oven (regular or microwave) plus at least one temperature-controlled heating unit, or at least two temperature-controlled heating units (but no functioning oven).

☐ My/our cooking or food storage facilities are temporarily not working and are not expected to be working until ___/___/___
(*Enter date*)

I understand the California Restaurant Meals allowance ends with the month I receive meals as part of my living arrangement or I have access to adequate cooking and food storage facilities.

I agree to immediately notify Social Security Administration if there is any change in my living arrangement as described above.

I know that anyone who makes or causes to be made a false statement or representation of material fact in an application or for use in determining a right to payment under the Social Security Act commits a crime punishable under Federal Law and / or State Law. I affirm that all information I have given in this document is true.

SIGNATURE OF PERSON (S) MAKING STATEMENT	
Signature *(First name, middle initial, last name) (Write in ink)* **SIGN HERE** _____ **SIGN HERE** _____	**Date** *(Month, day, year)* ___/___/___ ___/___/___
Mailing Address *(Number and street, Apt. No., P.O. Box, Rural Route)*	**Telephone Numbers** *(include Area Code)* **Home ( ) -** **Work ( ) -**
City and State	**ZIP Code**

SSA Decision: ☐ Approved effective ___/___/___ ☐ Denied ☐ Notice of Planned Action provided ☐ Redetermination only			
By: *(Print Name)*	**Signature:**	**Title:** ☐ CR ☐ SR ☐ TE ☐ _____	**Date:**
Social Security Administration, American River Field Office, 5839 Manzanita Ave. Suite 6, Carmichael, CA. 95608			

Form SSAFO-E77-7527 (3/10/03)

Form Approved
OMB No. 0960-0045

SOCIAL SECURITY ADMINISTRATION

STATEMENT OF CLAIMANT OR OTHER PERSON

NAME OF WAGE EARNER, SELF-EMPLOYED PERSON, OR SSI CLAIMANT	SOCIAL SECURITY NUMBER – –
NAME OF PERSON MAKING STATEMENT *(If other than above wage earner, self-employed person, or SSI claimant)*	RELATIONSHIP TO WAGE EARNER, SELF-EMPLOYED PERSON, OR SSI CLAIMANT

Understanding that this statement is for the use of the Social Security Administration, I hereby certify that -

1. What city are you primarily homeless in?
2. On average where can you be found (landmarks)?
3. What is your daily routine?
4. Where do you primarily sleep at night?
5. Do you have a mailing address? YES ☐ NO ☐
6. If yes, what is your mailing address?
7. If yes, what day do you pick up your mail?
8. Do you reside at this address? YES ☐ NO ☐

Please sign the back

Privacy Act Statement

Collection and Use of Personal Information

Public Law 110-328 and section 1631(e) of the Social Security Act, as amended, authorize us to collect this information. The information you provide will be used to determine if you have made a good faith effort to pursue U.S. Citizenship, so that we may make a decision on additional Supplemental Security Income (SSI) benefits.

The information you furnish on this form is voluntary. However, failure to provide the requested information will prevent us from making a timely decision on your benefits.

We generally use the information you supply for the purpose of determining eligibility for benefits. However, we may use it for the administration and integrity of Social Security programs. We may also disclose information to another person or to another agency in accordance with approved routine uses, which include but are not limited to the following:

1. To enable a third party or an agency to assist Social Security in establishing rights to Social Security benefits and/or coverage, including the U.S. Citizenship and Immigration Service in order to verify information provided;

2. To comply with Federal laws requiring the release of information from Social Security records (e.g., to the Government Accountability Office and Department of Veterans' Affairs);

3. To make determinations for eligibility in similar health and income maintenance programs at the Federal, state, and local level; and

4. To facilitate statistical research, audit or investigative activities necessary to assure the integrity of Social Security programs.

We may also use the information you provide in computer matching programs. Matching programs compare our records with records kept by other Federal, state, or local government agencies. Information from these matching programs can be used to establish or verify a person's eligibility for Federally funded or administered benefit programs and for repayment of payments or delinquent debts under these programs.

Additional information regarding this form, routine uses of information, and our programs and systems, is available on-line at www.ssa.gov or at your local Social Security office.

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 15 minutes to read the instructions, gather the facts, and answer the questions. **SEND THE COMPLETED FORM TO YOUR LOCAL SOCIAL SECURITY OFFICE. The office is 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 Boulevard, Baltimore, MD 21235-6401.* ***Send only comments relating to our time estimate to this address, not the completed form.***

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 or misleading statement about a material fact in this information, or causes someone else to do so, commits a crime and may be sent to prison, or may face other penalties, or both.

SIGNATURE OF PERSON MAKING STATEMENT

Signature *(First name, middle initial, last name) (Write in ink)*	Date *(Month, day, year)*
SIGN HERE ▶	Telephone Number *(Include Area Code)* ( ) –
Mailing Address *(Number and street, Apt. No., P.O. Box, Rural Route)*	
City and State	ZIP Code –

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 individual must sign below, giving their full addresses.

1. Signture of Witness	2. Signture of Witness
Address *(Number and street, City, State, and ZIP Code)*	Address *(Number and street, City, State, and ZIP Code)*

If client is renting a room- Fill out the attached forms

- Landlord Statement (Landlord completes)
- Renters Statement (Client Completes)
- Proof of rental liability from landlord (*Examples: Utility bill for the stated address in the landlords name or a copy of the landlords ID)*

Sign where marked and answer all required questions

If the client:

- ✓ Is responsible for utilities and /or signed a lease or rental agreement
- ✓ Lives in a assisted living or medical facility

Then..

DISREGARD these forms and attach a copy of the agreement

SOCIAL SECURITY ADMINISTRATION

STATEMENT OF CLAIMANT OR OTHER PERSON

NAME OF NUMBER HOLDER	**SOCIAL SECURITY NUMBER** *(of NH)*
NAME OF PERSON MAKING STATEMENT *(If not NH)*	**RELATIONSHIP** *(to NH)*

RENTER'S STATEMENT – Room Rental in Private Residence

Understanding that this statement is for the use of the Social Security Administration, I hereby certify that...

- Beginning _____ I am paying $_____ per month for room rent in the landlord's
  (Print date)

  _____ located at the following address:
  (Enter "apartment", "trailer", "house", etc.)

  _____

  _____

  _____.

- I have access to adequate food storage and cooking facilities. ☐ Yes ☐ No
- I am in a separate household from the landlord (I have no right to make any decisions in the running of the landlord's household). ☐ Yes ☐ No
- Is the renter related to the landlord as parent or child? ☐ Yes ☐ No
- I need assistance with my personal care or hygiene or in upkeep of my home. ☐ Yes ☐ No
  Examples are help with bathing, eating, dressing, taking medication, with caring for your room or moving about.

We may also use the information you give us when we match records by computer. Matching programs compare our records with those of other Federal, State or local government agencies. Many agencies may use matching programs to find or prove that a person qualifies for benefits paid by the Federal government. The law allows us to do this even if you do not agree to it.

Explanations about these and other reasons why information you provide us may be used or give out are available in Social Security Offices. If you want to learn more about this, contact any Social Security Office.

I know that anyone who makes or causes to be made a false statement or representation of material fact in an application or for use in determining a right to payment under the Social Security Act commits a crime punishable under Federal Law and /or State Law. I affirm that all information I have given in this document is true.

SIGNATURE OF PERSON MAKING STATEMENT	
Signature *(First name, middle initial, last name) (Write in ink)* **SIGN HERE**	**Date** *(Month, day, year)*
Mailing Address *(Number and street, Apt. No., P.O. Box, Rural Route)*	**Telephone Numbers** *(Include Area Code)* **Home ( ) -** **Work ( ) -**
City and State	**ZIP Code**

SOCIAL SECURITY ADMINISTRATION

STATEMENT OF CLAIMANT OR OTHER PERSON

NAME OF NUMBER HOLDER *(Renter)*	**SSN** *(of NH—Complete **after** return from landlord.)*
NAME OF PERSON MAKING STATEMENT *(Landlord)*	**RELATIONSHIP** *(to NH)*

LANDLORD'S STATEMENT – Room Rental in Private Residence

Understanding that this statement is for the use of the Social Security Administration, I hereby certify that...

- Beginning _____ the following person _____
  (Print date) ***(Print renter's full name)***

  is paying $_____ per month for room rent in my _____
  (Enter "apartment", " trailer", "house", etc.)

  located at this address: _____

  _____

  _____.

- The renter has access to adequate food storage and cooking facilities. ☐ Yes ☐ No
- I consider the renter to be in a separate household (he/she has no right to make any decisions in the running of my household). ☐ Yes ☐ No
- Is the renter related to the landlord as parent or child? ☐ Yes ☐ No

Other Remarks: _____

_____

We may also use the information you give us when we match records by computer. Matching programs compare our records with those of other Federal, State or local government agencies. Many agencies may use matching programs to find or prove that a person qualifies for benefits paid by the Federal government. The law allows us to do this even if you do not agree to it.

Explanations about these and other reasons why information you provide us may be used or give out are available in Social Security Offices. If you want to learn more about this, contact any Social Security Office.

I know that anyone who makes or causes to be made a false statement or representation of material fact in an application or for use in determining a right to payment under the Social Security Act commits a crime punishable under Federal Law and /or State Law. I affirm that all information I have given in this document is true.

SIGNATURE OF PERSON MAKING STATEMENT	
Signature *(First name, middle initial, last name) (Write in ink)* **SIGN HERE**	**Date** *(Month, day, year)*
Mailing Address *(Number and street, Apt. No., P.O. Box, Rural Route)*	**Telephone Numbers** *(Include Area Code)* **Home ( ) -** **Work ( ) -**
City and State	**ZIP Code**

-Direct Deposit-

For our clients convenience we offer Direct Deposit. We offer both Direct Deposit into your existing bank account or CEPS is happy to enroll the client for a RAPID pay card.

Direct Deposit is a convenient way to access your funds quicker and ensure deliver of funds without waiting on the mail as well as avoiding unnecessary check cashing fees.

To sign up for the RAPID pay card or enroll in Direct Deposit with your personal bank account please find the attached enrollment form on the following page. If you are using an existing bank account you will also need to provide a voided check or a document from your bank with the client name, routing and account number present.

Once signed up:

It generally takes 7-10 days once the enrollment form is completed to begin receiving any available deposits. If you requested to use a RAPID pay card it will distribute to you within 10 days.

COMMUNITY ENGAGED PAYEE SUPPORT

Direct Deposit and Paycard Information

CEPS is pleased to be able to provide the option of using direct deposit for our clients who have bank accounts or the Rapid! paycard.

Here are some things you should know about Direct Deposit to your bank account or to your Rapid! paycard:

- Pending Rapid! approval, it takes 7 to 10 days after you enroll or activate your card to receive your first deposit. Your current direct deposit or pay card will be cancelled and you will receive paper checks while your application is processed.
- Direct Deposit is not available on weekends or bank holidays. If you are expecting a direct deposit on a Monday that is a bank holiday, you will receive it on the following Tuesday after the holiday.
- SSA still requires that you provide receipts when you are on direct deposit. You can hand deliver, fax, or mail in your receipts.
- If we do not receive your funds from Social Security in a timely manner your direct deposit may be delayed or stopped. Therefore, we do not recommend signing up for autopay or bill pay.
- If you have a mobile phone you can download the Rapid! App and sign up for text alerts for FREE.
- You agree to inform CEPS immediately if your phone number or address changes. If we are unable to reach you, we will stop sending payments.

One Time Cost of Card	Waived
Allpoint & MoneyPass ATM Withdrawal	**$0.00**
Other ATM Withdrawal	**$2.50**
POS Transaction Denials	**$0.50**
Other ATMs Balance Inquiries	**$0.99**
ATM denials	**$0.75**
Allpoint & Money Pass Balance Inquiries	**$0.00**
Monthly Fee Deducted from your CEPS account	$0.00
POS Mastercard transaction (swipe card as credit)	$0.00
Balance Inquiry via IVR (Interactive Voice Response-Telephone)	$0.00
POS – Pin purchase (using your card at a store with your pin #)	$0.00
Card Replacement - First is FREE/Then $5 (Lost Card 10 days)	$5.00
Inactivity Fee	$4.95

If you would like to take advantage of this valuable service, please fill out the reverse side and mail or fax it (with a voided check for direct deposit) to:

Locations

CEPS Sacramento
ATTN: Direct Deposit
3111 Fulton Ave Ste 101
Sacramento, CA 95821

CEPS Modesto
ATTN: Direct Deposit
529 14th St
Modesto, CA 95354

Info@CEPSonline.org

www.CEPSonline.org

COMMUNITY ENGAGED PAYEE SUPPORT

☐ **Client Paycard** ☐ **Client Acct** ☐ **Landlord/Vendor Acct** ☐ **Multiple CEPS Locations**

Direct Deposit Authorization Agreement

I hereby authorize CEPS to initiate automatic deposits to my account or to my Rapid! paycard at the financial institution named below. I understand that if Social Security does not send funds in a timely manner or we do not have contact with you, the direct deposit may be delayed or stopped. Due to this possibility, setting up autopay or bill payment from your account is not recommended and is at your own risk.

In the event funds are deposited erroneously into my account, I authorize CEPS to debit my account(s). I understand that CEPS reserves the right to refuse any direct deposit request. I also understand that all direct deposits are made through the Automated Clearing House (ACH), and that funds availability is subject to the terms and limitations of the ACH as well as my financial institution.

Further, I agree not to hold CEPS responsible for any delay, loss of funds, or fees due to incorrect or incomplete information supplied by me or by the financial institution or due to an error on the part of the financial institution or CEPS in depositing funds to my account. Terms and Conditions are subject to change.

By signing below, I acknowledge that this agreement will remain in effect until CEPS receives a written notice of cancellation from me or my financial institution, until I submit a new direct deposit form to CEPS, or discontinue my services with CEPS.

Direct Deposit Account Information

Client Name:_____ Account Holder:_____

Account Holder Email:_____

Name of Financial Institution: _____ Checking ☐ Savings ☐

Routing Number:_____ Account Number:_____

Please attach a voided check or bank statement and return with this form.

Rapid! Paycard Account Information

First Name: _____ MI: _____ Last Name: _____

Phone Number: ---------- _____ Type: Cell ___ Home ___ Msg ___

Physical Address: _____

City: _____ State: _____ Zip Code: _____

Birthdate: _____/ _____/ _____ Verify Birthdate: _____/ _____/ _____

SSN: _____- _____- _____Verify SSN ---------- _____

*** Use CEPS physical address if the client DOES NOT have a permanent residence.**

Signature

By signing below I acknowledge that I have read and understand all of the above. I also understand that my account and agreement is with the financial institution I have selected above. This indemnification and hold harmless agreement shall include indemnity against all costs (including without limitation, reasonable attorney's fees and court costs), expenses and liabilities incurred in or in connection with any such claim or proceeding brought thereon and in defense thereof. CEPS is not responsible for any fees incurred and the use and care of your account, card, and pin is your responsibility. I agree to NOT share my PIN. Paycards are pending a 7-10 day Rapid! approval.

Authorized Signature (Primary):_____Date: _____

AM:_____Corp: _____

CEPS will also need..

1. Photo of the client (Neck and above)
2. Copies if available of a photo ID and medical insurance cards
3. Copy of Social Security card
4. Signed Medi-Cal form MC306 attached (CA residents only)
5. Copies of any bills the client is responsible for

If the client has a bill with one of the below, we will need additional attached releases signed also.

- Pacific Gas & Electric Co.

APPOINTMENT OF REPRESENTATIVE

SECTION I. TO BE COMPLETED BY APPLICANT/BENEFICIARY

Name	Case number *(optional)*	Date

I appoint this individual _____ / _____
Name of individual ***Name of organization***

Complete address Telephone number

as my authorized representative to accompany, assist, and represent me in my application for, or redetermination of, Medi-Cal benefits.

THIS AUTHORIZATION ENABLES THE ABOVE NAMED INDIVIDUAL TO:

- submit requested verifications to the county welfare department;
- accompany me to any required face-to-face interview(s);
- obtain information from the county welfare department and from the State Department of Social Services, Disability Evaluation Division, regarding the status of my application;
- provide medical records and other information regarding my medical problems and limitations to the county welfare department or the State Department of Social Services, Disability Evaluation Division;
- accompany and assist me in the fair hearing process; and
- receive one copy of a specific notice of action from the county welfare department, at the request of the applicant/beneficiary.

I UNDERSTAND THAT I HAVE THE RESPONSIBILITY TO:

- complete and sign the Statement of Facts;
- attend and participate in any required face-to-face interview(s);
- sign MC 220 (Authorization for Release of Medical Information);
- provide all requested verifications before my Medi-Cal eligibility can be determined; and
- accept any consequences of the authorized representative's actions as I would my own.

I UNDERSTAND THAT I HAVE THE RIGHT TO:

- choose anyone that I wish to be my authorized representative;
- revoke this appointment at any time by notifying my Eligibility Worker; and
- request a fair hearing at any time if I am not satisfied with an action taken by the county welfare department.

Applicant/Beneficiary's signature	Date
➤	

Address

SECTION II. TO BE COMPLETED BY THE AUTHORIZED REPRESENTATIVE NAMED. ***LAW FIRMS, ORGANIZATIONS, AND GROUPS MAY REPRESENT THE APPLICANT/BENEFICIARY BUT AN INDIVIDUAL MUST BE DESIGNATED AS THE CONTACT PERSON TO ACT ON THE APPLICANTS/BENEFICIARIES BEHALF.***

I HEREBY ACCEPT THE ABOVE APPOINTMENT AND UNDERSTAND THAT:

- the applicant/beneficiary may revoke this authorization at any time and appoint another individual(s) to act as his/her authorized representative;
- I have no other power to act on behalf of the applicant/recipient, except as stated above;
- I may not act in lieu of the applicant/beneficiary; and
- I may not transfer or reassign my appointment without a new Appointment of Representative form being completed by the applicant/recipient.

I CERTIFY THAT:

- I have not been suspended or prohibited from practice before the Social Security Administration
- I am not, as a current or former officer or employee of the United States, disqualified from acting as the applicant's representative; and
- I am known to be of good character.

This authorization is recognized for one year from the date signed by the applicant unless revoked earlier as described in Section 1 above.

Authorized representative's signature	Employed by	Date	Telephone number
➤			

COUNTY USE ONLY

Date verbal request to revoke received Date written request to revoke received Request received from:

EW name: _____ Telephone number: _____

Do you have a relative or friend who may forget their PG&E bill?

Here's a caring way to help.

Third Party Notification Service helps ensure your loved ones receive the gas and electric services that keep them safe and comfortable.

If someone you care for can't always keep up with bills, help see that their PG&E service remains uninterrupted. Take advantage of our *Third-Party Notification Service.*

Should that special person get a late notice, we'll do our best to let you know. You're not obligated to pay the bill-but you'll be alerted to contact PG&E to help resolve the problem.

Use the form on the other side to sign up. And know that your caring can make a difference. *Complete Form On Other Side*

For more information call **I.800.PGE.5000**

PG&E

Request for *Third-Party Notification Service*

Please complete in full. Requires signature of both Customer and Third Party.

CUSTOMER

ACCOUNT NUMBER AS SHOWN ON BILL

CUSTOMER NAME IPLEASE PRINTI

DAYTIME PHONE

MAILING ADDRESS

CITY/STATE/ZIP

I request that the designated Third Party be notified in case of nonpayment of my PG&E bill.

CUSTOMER SIGNATURE

PG&E can not be held liable for failure to notify Third Porty.

THIRD PARTY

NAME OF THIRD PARTY IPLEASE PRINTJ

OAYTIME PHONE

MAILING ADDRESS

CITY STATE ZIP

I understand that I am not obligated to pay any part of the customer's bill.

THIRD PARTY SIGNATURE

Enclose this form with your payment or send ta Pacific Gas and Electric Company, P.O. Box 997300, Sacramento CA 95899-7300.