LIFESPAN
COMMUNITY FIRST SOLUTION

Representative Payee Intake

1. _____ Date: _____

_____ _____

Case Manager: _____ Phone: _____

Case Mgr. Email: _____ Program: _____

2. Client Full Name: _____

Address: _____

SSN: _____ DOB: _____

Phone #: _____ Mother's Maiden Name: _____

Roommates : _____ City/State of Birth: _____

3. Income Source: _____ Amount: _____

Income Source: _____ Amount: _____

Income Source: _____ Amount: _____

Food Stamps: _____ Amount _____

4. Reason for Referral: _____

Current Payee? _____ Name/Number: _____

Guardian? _____ Name/Number: _____

5. Demographics:

Race:

- ☐ American Indian or Alaskan Native
- ☐ Asian
- ☐ Black or African American
- ☐ Native Hawaiian or Other Pacific Islander
- ☐ White
- ☐ Other Race
- ☐ Refused/Unknown
- ☐ Two or more Races

Marital Status:

- ☐ Divorced
- ☐ Married
- ☐ Separated
- ☐ Single
- ☐ Widowed

Ethnicity:

- ☐ Hispanic or Latino
- ☐ Not Hispanic or Latino
- ☐ Cambodian
- ☐ Former Soviet Union
- ☐ Vietnamese

Gender: ☐ Male ☐ Female

LIFESPAN REPRESENTATIVE PAYEE TRUST AGREEMENT

I authorize Lifespan, Inc. to be my representative payee. I understand they will follow Social Security, Veterans' Administration, and or Railroad Retirement Benefits guidelines for managing my money, as appropriate. I will continue to be active in making decisions concerning my money. I understand I will have access to my money as outlined in my monthly budget.

_____

Signature **Date** **Print Name**

_____

Guardian Signature (if assigned) **Date** **Print Name**

(If client has a guardian, a copy of the guardianship papers is required for application)

***PLEASE COMPLETE FRONT AND BACK AND RETURN**

LIFESPAN
COMMUNITY FIRST SOLUTIONS

Representative Payee Program
1900 Fairgrove Avenue, Hamilton, OH 45011; (513)868-3210; F: (513)868-3249
Authorization for Use and Disclosure of Protected Health Care Info

Client Name: _____ Phone: _____

Address: _____
Street City State ZIP

I, _____hereby grant permission to LifeSpan, Inc. to
Name of client or parent/guardian
release, obtain, and/or exchange information with the following:

- □ Family / Significant Other(s) Involvement:
  Name: _____Phone: _____
- □ Social Security Administration
- □ DJFS_____ County/MITS enrollment verification
- □ Mental Health Case Management of _____ County
- □ Developmentally Disabled Program of_____ County
- □ Attorney / Legal:_____
- □ Communication with Landlords Name:_____
- □ Bill Vendors:_____
  _____
- □ Other:_____

Check/specify the information which shall be disclosed:

- □ Assessment/Health History/ Plan of Care
- □ Medication
- □ Financial Information: Income/Assets/expenses/insurance
- □ Other: _____
- □ All of the above

Initial the following:

_____ I understand that LifeSpan, Inc., when permitted by law, may release information about me without my informed, written consent such as in the event that I am deemed to be a threat to myself or others, if mandated reporting is required or upon subpoena. Otherwise, information may be shared as stated above in support of my continuing service needs.

_____ I understand communicating via text is not a secure means of communication so other means of communication (phone and e-mail) are preferable.

_____ I have received a copy of the Client Bill Of Rights and Responsibilities.

_____ I am aware I am responsible for a monthly payee fee, as allowed by the Social Security Administration.

This release is valid for 1 year. This release will be considered void upon case closure. I have been offered to receive a copy of this form. I may withdraw consent at any time.
Client received a copy of this disclosure: □ Yes

_____ _____ _____
Client or Client Parent/Legal Guardian Signature Relationship to Client Date

_____ _____
Staff Signature Date

<u>*PLEASE COMPLETE FRONT AND BACK AND RETURN</u>