

5300 Memorial Dr Suite 208F, Stone Mountain, GA 30083

APPLICATION FOR SERVICE

Client information

Name: _____

Address _____

City: _____ State _____ Zip _____

Date of Birth _____ Social Security # _____

Daytime Phone _____ Mobile _____

Place of Birth _____ Mother's maiden name _____

Father's name _____

Marital status: Married _____ single _____ Divorced _____

Emergency contact: (Name, phone# & relationship to you)

Case Manager's name _____ Phone# _____

Monthly Income

SSI _____ Amount \$ _____ SSA _____ Amount \$ _____

Other: _____ Amount \$ _____

Additional Information or (Landlord)

Signature: _____ Date: _____

REPRESENTATIVE PAYEE CONTRACT

I, _____ (client name) hereby appoint PEOPLES CHOICE PAYEE SERVICES to be my designated Representative Payee for my social security benefits, SSI, SSD or other income. People's Choice shall receive my benefits or pay checks and be responsible to pay my financial obligations to the extent that there are available funds to in my account to do so. Client agrees to pay a FEE of **\$42.00** per month* to People's Choice. People's Choice will pay Rent and Utilities (or Room & Board) and other bills directly to the service provider. We will provide a weekly personal needs check to the Client to the extent that People's Choice has client funds available to do so. We shall provide all designated Representative Payee services as prescribed by law or regulation.

The Client agrees to the following:

1. People's Choice will make all payments by check and will mail by US Postal Service First Class Mail only.
2. All weekly checks will be mailed by Wednesday of each week (Holidays & Emergencies exception) and all rent checks will be mailed within 2 business days of receipt of Client funds each month.
3. The Client must notify us in writing of any changes in address. If the Client fails to notify People's Choice in writing of any changes in address at least 10 days before the change or move, we shall be held harmless by the client for any rent, room & board or other payments made by People's Choice on the Clients behalf.
4. Special funds request will be mailed on the Wednesday following the week of the request. Exceptions to the above will be made only in the case of homelessness or medical emergency.
5. People's Choice will make no advances or loans.
6. The Client must notify People's Choice if they become employed in writing, therefore we can accurately report this information to the Social Security Administration. I understand if I fail to notify People's Choice, then I will be responsible for any overpayment and People's Choice will not be liable.
7. **The Client agrees to remain with People's Choice for a minimum period of 12 months or an Early Termination Charge will be incurred of \$42.00 per month x number of months remaining if shorter than 12 months.**

The Client acknowledges that People's Choice assumes no responsibility or liability to the Client or others in making disbursements provided the disbursements are made in accordance with the written instructions of the Client and or within the Social Security Administration Guidelines for Representative Payees and other legal or regulatory requirements.

This agreement shall remain in force for a period 12 months from the date of execution and shall be automatically renewed unless cancelled by the Client with written 30-day notice.

People's Choice reserves the right to provide a Client cancellation notice to Social Security at any time.

CLIENT SIGNATURE: _____ DATE: _____

*Client fees are regulated by Social Security and subject to change without notice. ***Revised***
2/21/2018

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Disability Questionnaire

- Have you worked for someone in the past three years? Yes No. If yes where, please give date.

Work began-

Work ended-

Monthly earnings -

- Have you attended any school or work training in the last three years? Yes or No
- In the last three years to present have you discussed whether you can work or not work?
 - I have not discussed if I can work.
 - My doctor told me I cannot work.
 - I can work.

Check which best describe your health now as compared to three years ago.

- Better b. Same c. Worse
- Have you to a doctor or clinic for treatment including evaluations, checkups, counseling, prescriptions or medicine? If yes when and where.
- Have you been hospitalized or had surgery in the past three years? Yes or No
- d. if you answered yes to Item C please list reason for hospitalization or Surgery.

Client signature _____

Date _____

People's Choice
List of Client Payments

Name: _____ Address: _____ _____ _____ Account #: _____ Phone #: _____ Amount: \$ _____ Date Due: _____ Begin ASAP	Name: _____ Address: _____ _____ _____ Account #: _____ Phone #: _____ Amount: \$ _____ Date Due: _____ Begin ASAP
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Name: _____ Address: _____ _____ _____ Account #: _____ Phone #: _____ Amount: \$ _____ Date Due: _____ Begin ASAP	Name: _____ Address: _____ _____ _____ Account #: _____ Phone #: _____ Amount: \$ _____ Date Due: _____ Begin ASAP
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Personal Allowance Amount: \$ _____

How Often: _____

Case Manager: _____

Date: _____