Cache Integrity Services
777 N Crusey St, STE B110
Wasilla AK 99654

REPRESTANATIVE PAYEE INTAKE

Dear Service Coordinator,

Attached you will find our 4-page intake form and the required releases. Please follow the instructions carefully. After you have completed the intake forms and gather the required signatures, all of the documents should be mailed to the address above. We MUST HAVE the original signatures – please mail after faxing to 907-308-6799.

Authorization for Payeeship: Please use ink when completing this form. Complete both the consumer's name, SSN and SSA Claim Number in the top right corner. (The SSA claim number is the number under which the consumer is receiving SSA benefits) If the consumers signs with an X or a mark, there must be 2 witness signatures at the bottom portion of this form.

CIS – Consent to Exchange Information: Please use ink when completing this form. This form was developed so we can obtain and exchange information about the consumer for the purposes of either acting as the payee or paying their bills. Please fill in the consumer's name, Social Security Number and Date of Birth at the top of this form. Review this form with the consumer explaining all types of information we may ask for and with whom it may be shared. If the consumer objects to any item, you should place a line through that particular item(s). Have the consumer sign and date the form. If the consumer signs with an X or a mark, 2 witness signatures are required at the bottom of this form.

Authorization for Social Security to Obtain Personal Information: This is a Social Security form and is requested upon intake. Please enter the Consumer's Name and SSN on the first line. Have the consumers sign the middle section by the arrow. IF the consumer signs with an X or a mark, 2 witness signatures are required at the bottom of this form.

Budget Worksheet: This page is used to tell us who to pay, where to mail payment and how often money is to be sent. We run checks weekly. We are closed on all federal holidays. We will also be closed the last working day of the month to review the next month's budgets. If your consumer wants money sent to them on a particular day of the month and that day falls on a weekend or holiday the check will be sent out the working day before. If you need help, please schedule a time

Please complete the consumer's name and SSN as well as the SSA claim number if the consumer is receiving SSA. When working on a budget for a consumer, you need to know how much money the consumer gets each month. Next you should write the amount received in the income section. Please give your best estimate for the monthly amount spent on: rent, utilities, food, etc. For food and personal spending, please advise both how often your consumer would like these funds mailed (weekly, biweekly, monthly, semi-monthly or on a specific day of the month).

When figuring out the amounts for food and personal spending, please calculate based on a 5-week month – as we don't want to run short on funds! **Make sure that the total monthly expenses do not exceed the total monthly income received.**

The consumer, with help from their CC agency, should contact any utility company you have indicated on this form and request the mailing address of their bill be changed to our address **777 N Crusey St, STE B110, Wasilla AK 99623.** The CC agency should remind the consumer that if they continue to receive their bill this means CIS is not and they should again contact the utility company to request a change of address.

CIS Representative Payee Intake Form: This is a 4-page form requesting biographical information about your consumer. Please send copies of requested documents when instructed. Please fill in all areas. If any area does not apply, draw a line through it and write N/A.

After all forms have been completed, they should be mailed to Cache Integrity Services at the address above.

If you have any questions feel free to contact Tom McDuffie at CIS to operations@cacheintegrityservices.com or call 907-631-2000.

Tom McDuffie, Executive Director CIS

Authorization for Payeeship
Advance Notification of Representative Payment

Client Name _____ **SSN** _____

SSA Claim # _____

AUTHORIZATION FOR PAYEESHIP

I_____hereby authorize Cache Integrity Services (CIS) to file an application for payeeship and to become payee for any SSI/SSA benefits I may be eligible to receive. I understand these benefits will be administered by Cache Integrity Services.

I hereby consent and authorize Cache Integrity Services and the Social Security Administration to disclose benefits eligibility payment information about me for use in applying for Social Security benefits, Supplemental Security benefits, Railroad benefits, Veterans benefits, Civil Service Annuity benefits, PFD Benefits, and Native dividend benefits I may be eligible to receive as well as for planning and providing services for me. This authorization will remain in effect for the duration of time for which Cache Integrity Services is my representative payee.

NEED FOR REPRESENTATIVE PAYEE
The Social Security Administration (SSA) had 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 interest.

CHOICE OF REPRESENTATIVE PAYEE
SSA has selected Cache Integrity Services to be my representative payee.

MY RIGHT TO APPEAL
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 also have the right to appeal the decision that I need a payee. If I appeal, I will have the right to review the evidence in the file and submit new evidence.

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.

Client Signature _____ **Date** _____

Legal Representative Signature _____ **Date** _____

Witnesses are required only if this statement has been signed by an (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 address.

1.) Signature of Witness	2.) Signature of Witness
Address (Number and Street, City, State, Zip Code)	Address (Number and Street, City, State, Zip Code)

Cache Integrity Services

777 N Crusey St, STE B110, Wasilla AK 99654

Consent to Exchange Information

I, the Consumer/Parent/Guardian or Conservator of:

CONSUMER Name: _____

SSN: _____

Date of Birth: _____

Authorize CIS, and its employees to obtain the following type of information/records:

☐ Educational	☐ Social	☐ Wage Information
☐ Medical/Dental	☐ Vocational	☐ Psychological
☐ Individual Program Plan	☐ Utility Bills	☐ Other (Specify)

This information shall be used for the purposes indicated below:

☐ Social Security Eligibility	☐ Paying my bills
☐ Social Security Re-determination	☐ Social Security CDR

☐ Other (Specify) _____

This authorization shall be valid for a period of one year from the date signed, until_____, or until revoked in writing.

Consumer signer: _____

Date: _____

Witnesses are required only if this statement has been signed by an (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 address.

1.) Signature of Witness	2.) Signature of Witness
Address (Number and Street, City, State, Zip Code)	Address (Number and Street, City, State, Zip Code)

SOCIAL SECURITY ADMINISTRATION

AUTHORIZATION FOR THE SOCIAL SECURITY ADMINISTRATION TO OBTAIN PERSONAL INFORMATION

Authorizing Person (Person about whom information is being requested)	Social Security Number
Claimant/Beneficiary (If other than authorizing person)	Claimant's/Beneficiary's Social Security Number

I authorize any public or private custodian of records to disclose to the Social Security Administration any records or information about me. In the case of a minor or incapable person, I, as guardian or representative, authorize the same disclosure of records about the person I represent.

Authorizing Person's Signature **SIGN HERE** →		Date
Mailing Address	City and State	ZIP Code

Your authorization does not ordinarily have to be witnessed. However, if you have signed by mark (X), two witnesses to the signing who know you must sign below giving their full addresses.

1. Signature of Witness	2. Signature of Witness
Address (Number, Street, City, State, ZIP Code)	Address (Number, Street, City, State, ZIP Code)

Form **SSA-8510** (9-87)

CIS Representative Payee Intake Form

First Name Last Name Mi

SSN: _____

SSA Claim #: _____ - _____

_____

Sex: _____ DOB: _____ Place of Birth _____ State _____

Legally Blind: Yes No (Check One) **Deaf:** Yes No (Check One)

Is consumer conserved? Yes No (Check One)

If consumer is conserved, please attach copy of conservatorship papers and fill in below:

Name: _____ Phone: _____

Living Arrangements

Address: _____

City: _____ St: _____ Zip: _____

Phone: _____

Description of Living Arrangements

(Check one)

Alone in own apt/home
Sharing apt/home with roommates

Date Moved In: _____
(mo/yr)

Landlord name: _____

City: _____ St: _____ Zip: _____

Phone: _____

Employment Information

Employer Name:_____Date Started Working _____

Employer Mailing Phone:_____

Address: _____

City:_____St:_____Zip: _____

How often paid: Weekly Every 2 Weeks Twice a Month Monthly Piece Work (Check One)

Last Date Paid:_____(mo/day/year)

Paid by the: Hour Piece (Check One)

Rate of Pay: $ _____ Average Check: $ _____

Resources: Cash on Hand

Cash on Hand:_____as of_____(mo/day/yr)

Resources: Checking Account

Bank Name: _____

Acct. # _____ Balance: $_____ as of date _____

Interest Bearing: Monthly Quarterly None (Check One)

Please attach copy of current bank statement

Resources: Savings Account

Bank Name: _____

Acct. # _____ Balance: $_____ as of date _____

Interest Bearing: Monthly Quarterly None (Check One)

Please attach copy of current bank statement

Resources: Special Needs Trust

Trustee Name: _____

Address: _____

City: _____ St: _____ Zip: _____

Phone: _____

Please attach copy of Trust document

Resources: Burial Account

Where: _____

Amount/Balance: $ _____ Revocable Irrevocable (Check One)

Address: _____

City: _____ St: _____ Zip: _____

Phone: _____

Please attach copy of Burial document

Care Coordinator/Case Manager Agency Involved with Consumer

Agency Name: _____

Support Staff's Name:

Address: _____

Phone: _____ Fax: _____

Email: _____

Mother's Maiden Name: _____

Father's First Name: _____

State of Alaska
Department of Health & Social Services
Division of Public Assistance

PROTECTIVE PAYEE AGREEMENT

Check Program Choices

☐ Adult Public Assistance or Interim Assistance
☐ Senior Benefits Program

I, _____, agree to serve as protective payee

for _____.

I agree to receive and use the monthly Adult Public Assistance and/or Senior Benefits payment to meet the current needs of the person listed above. If requested, I agree to provide the Division of Public Assistance with an accounting of how the payments were used. I understand the Division may end my service or I may withdraw as payee at any time.

Tom McDuffie Digitally signed by Tom McDuffie Date: 2021.09.28 10:07:37 -08'00'

Signature of Payee _____ Printed Name _____ Date _____

Mail Address _____ Phone _____

How do you want to receive the assistance payments? Direct Deposit ☐ Mail ☐

- If by direct deposit, please contact your local Public Assistance Office or the Direct Deposit Office at 1-888-620-1111 to request a Direct Deposit Enrollment form.
- If by mail, where should the payments be sent?

  _____
  Mail Address
- Where should Medicaid coupons be sent?

  _____
  Mail Address
- Please attach proof of legal guardianship and/or Power of attorney if applicable.

I request that _____ be my protective payee.

I understand my payee will receive my monthly Adult Public Assistance and/or Senior Benefits payment and use the money to meet my current needs. I understand I must notify the Division of Public Assistance if I want to change my protective payee.

Signature of Recipient, Guardian, or Power of Attorney _____ Date _____

Distribution: APA case file
Senior Benefits case file

Emergency Contact Information Form

This information will be extremely important in the event of an accident or medical emergency.

Please be sure to sign and date this form

Name: _____
Last First MI

Phone:
Home: _____ **Cell:** _____

Home Email Address: _____

Address: _____
Street City State Zip Code

Primary Emergency Contact Name: _____
Last First

Relationship: _____

Phone:
Home: _____ **Cell:** _____ **Work:** _____

Secondary Emergency Contact Name: _____
Last First

Relationship: _____

Phone:
Home: _____ **Cell:** _____ **Work:** _____

Preferred Local Hospital: _____

Insurance Information:

Company: _____ **Policy #:** _____

Comments *(include any special medical or personal information you would want an emergency care provider to know – or special contact information:*

Signature: _____ **Date:** _____

Representative Payee Payment Contract

I _____ have discussed my needs with Cache Integrity Services and I agree to have Cache Integrity Services serve as my representative payee for Social Security or SSI payments.

I will:

- Be clean and sober when I come to conduct business,
- Treat Staff with courtesy and respect,
- I acknowledge that Cache Integrity Services will charge a monthly service fee of **$45.00** if they receive a Social Security benefit on my behalf.
- It is my responsibility to provide a copy of my leasing agreement to Cache Integrity Services and to provide the payee with my monthly bills so that they can be paid in a timely manner.
- I must notify Cache Integrity Services immediately if I have a change of address, hospitalization, incarceration etc.
- Provide receipts when receive extra spending money
- Come to conduct business only on:
  Monday - Thursday 10:00am-3:00pm
- I understand that if I fail to comply with these rules, Cache Integrity Services may refuse to continue to serve as my representative payee.

Cache Integrity Services will:

- Treat me with courtesy and respect • Be available to meet with me:
- Monday - Thursday 10:00am-3:00pm
- Use funds received on my behalf to meet my current needs for shelter, food, clothing and medical care
- Report to SSA any events that may affect my eligibility for payments or payment amount
- Account to SSA on how my money had been spent or saved
- Save any unspent funds saved for me (in the event of change in payee) or that were sent for my benefit but to which I am not entitled.

Beneficiary
Signature_____ Date _____

CIS
Signature Tom McDuffie Digitally signed by Tom McDuffie Date: 2021.09.28 10:24:54 -08'00' Date _____

Cache Integrity Services

777 N Crusey St, STE B110, Wasilla AK 99654

A 501(c)3 Non-Profit

VOLUNTARY REPRESTANATIVE PAYEE AGREEMENT

Voluntary Consent/Authorization & Request for Change of Payee Application

Client Name: _____ **Social Security #:** _____

AUTHORIZATION

I, _____ hereby give Cache Integrity Services my authorization to be my voluntary payee. I understand this means that they will receive any other funds outside of SSI/SSA/etc. funds that I am eligible for. I understand that they will administer my benefits for me.

MY NEED FOR A PAYEE AND MY SELECTION FOR MY PAYEE

The Social Security Administration has determined that I need assistance in managing my benefits. This means that my benefits will be sent to a representative payee who is responsible for managing my benefits in my best interest. I choose to have Cache Integrity Services serve also as my voluntary representative payee.

CONSENT TO CACHE INTEGRITY SERVICES PROGRAM REQUIREMENTS

A. I am aware that this is a voluntary program for a fee of $42.00/mo.

B. I understand that as part of this program, I will work with Cache Integrity Services Representative Payee contact to determine how my money will be spent.

C. Upon termination of my participation in the Voluntary Representative Payee Program, I understand any balance in my account with Cache Integrity Services will be returned to me.

Signed,

_____ _____

Client Date

_____ _____

Legal Representative (Guardian, Conservator, etc.) Date