

Date of request _____/_____/_____

PLAN of PA Application for Representative Payee Services

*Please note that an original signed application must be mailed to PLAN of PA in order to be placed on our waiting list.

Client Information

Name _____

Address - (No P.O. Box) _____

Telephone (_____) _____ County _____

SS# _____ DOB _____/_____/_____

Sources of Income – SSD \$ _____ SSI \$ _____ VA \$ _____ Payroll/Other: \$ _____

Married _____ Single _____ Children Yes _____ No _____

Living Situation _____

Does Client have a court appointed legal guardian? Yes _____ No _____

Does the Client currently have a representative payee? Yes _____ No _____

If yes, please explain why this change is being requested. _____

PLAN of PA only provides representative payee services to adults (18+) who have been diagnosed with a mental disability (mental illness, mental retardation, brain injury, autism.) Please provide the following:

1) individual’s diagnosis 2) date of diagnosis, and 3) name of title of who made the diagnosis:

1) _____

2) _____

3) _____

I am requesting that PLAN of PA serve as representative payee for my Social Security benefits. I understand that my benefits will be deposited into a checking account and that **I will not have direct access** to the funds. I also understand that there will be a fee for this service in accordance with Social Security Administration rules and regulations. I also give permission for PLAN of PA to talk and share relevant information with the Social Security Administration, financial institutions, mental health/residential staff and other appropriate resources working with and on behalf of me. That permission will remain in effect during the time that PLAN of PA is holding my funds.

Signature of Client: _____

Case Manager Name: _____ Signature: _____

Name of Agency: _____

Phone # (_____) _____ Fax # (_____) _____