Representative Payee Services

Client Intake Packet

BENEFITS MANAGEMENT CORPORATION / LIFE
2640 Cordova Lane, Suite 101
Rancho Cordova, CA 95670
P.O. Box 168045 Sacramento, CA 95816

297 Commercial Street, Suite 700
San Jose, CA 95103

Toll Free Phone: 866-622-3098 Toll Free FAX: 866-606-3248
Website: www.webpayee.com

Benefits Management Corporation

Living In Familiar Environments

Benefits Management Corporation and
Living in Familiar Environments
2640 Cordova Lane • Ranch Cordova, CA 95670
297 Commercial Street, Suite #700 • San Jose, CA 95112
www.webpayee.com * Phone (866) 622-3098 * Fax (866) 606-3248

Instructions for Completing the Client Intake Packet

1. Complete all of the forms included in this document and ensure client signs where designated. (The Budget Worksheet is optional – See #5 below).

2. Obtain and submit 2 forms of identification – preferably 1 photo I.D. and 1 other form of I.D. such as:
   a. CA driver license, CA Identification Card, Veterans' Administration Identification
   b. Social Security Card

3. If possible, provide a copy of the client's Medi-Cal Card.

4. In order to assist in developing an accurate budget, please provide copies of the following bills, if applicable:
   a. Rental agreement – it is ***vital*** we receive this document immediately. Without a rental agreement, Social Security benefits can be delayed.
      i. (if you do not have a rental agreement, you may download one from the resources page of our website. www.webpayee.com)
   b. Utilities such as SMUD and/or P G & E
   c. City or county water, sewer & garbage bills

5. You may complete and submit budget worksheet yourself/with your client. This is helpful if you/your client has bills such as cell phone or auto insurance that will be paid out of personal and incidental funds making it is necessary to have those funds dispersed at a particular time of month. The Benefits Management Corp / LIFE staff will review the worksheet you submit and work with you/your client if adjustments are necessary to ensure benefit lasts for the entire month.

6. Ensure client receives a copy of pages 16-20 of the intake packet for his/her records:
   Client Agreement - Processes and Procedures, What Happens During Intake, What Happens After I Sign Up.

7. Fax the completed intake packet to: 866-606-3248 or you may submit via email to: agency@webpayee.com.

CLIENT INTAKE

Date: ____________________

LAST NAME FIRST MI	SOCIAL SECURITY NUMBER
DATE OF BIRTH	PLACE OF BIRTH
REFERRING AGENCY	CONTACT PERSON PHONE NUMBER
AGENCY WEBSITE	CONTACT PERSON EMAIL

LIVING ARRANGEMENT

C/O ____________________ Telephone Number ____________________

Street Address ____________________ Move In Date ____________________

City, State, Zip Code ____________________ Monthly Rent Amount ____________________

Do you live alone? ☐ **Yes** ☐ **No**

If no, whom do you live with?

NAME	RELATIONSHIP

NOTES:____

____

____

Benefits Management CORPORATION
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INCARCERATION

JAIL / PRISON LOCATION: ____

DATE IN: ________________________________ DATE OUT: __________________________

X-REF#: _________________________________ CDC#: _______________________________

PAROLE / PROBATION OFFICE NAME: ____

OFFICE TELEPHONE #: ____

SOCIAL SECURITY INFORMATION

CLAIM REP: ______________________ CLAIM OFFICE: ______________________

BENEFITS: SSI: ____________ SSA: ______________

OVERPAYMENT: ☐ YES ☐ NO BALANCE: __________________________

RESOURCES:

____

____

____

FROM OUT OF STATE: ☐ YES ☐ NO

DATE ENTERED STATE? __________ PROOF OF ENTRY: ☐ YES ☐ NO

NEW CLAIM

SSA OFFICE: _____________________ REP: ________________________________

NOTES:

____

____

____

ATTORNEY: ☐ YES ☐ NO NAME: ___________________________________

PHONE #: _______________________________

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OTHER BENEFITS

VA: $__________ CLAIM#: __________ RRR: $____________ CLAIM# ____________

OTHER: NAME __________________ $__________ CLAIM# __________________

OTHER: NAME __________________ $__________ CLAIM# __________________

UNEARNED INCOME

CHECK ALL THAT APPLY

☐ PRIVATE PENSION ☐ AFDC / GA / FOODSTAMPS ☐ RENTAL INCOME

☐ UNEMPLOYMENT ☐ ALIMONY ☐ CHILD SUPPORT

☐ DIVIDENDS ☐ ROYALTIES ☐ TRUST FUND

WAGES

☐ YES ☐ NO EMPLOYER: ____

CONTACT INFO: ____

REMIND CLIENT TO TURN IN COPIES OF PAYSTUBS MONTHLY. IF NOT TURNED IN TO SSA, THIS MAY CAUSE AN OVERPAYMENT AND A LARGE WAGE ESTIMATE ON THE CLIENT'S RECORD. GIVE CLIENTS STAMPED ENVELOPES

RESOURCES

THE RESOURCE LIMIT IS $2000 FOR A SINGLE PERSON AND $3000 FOR A MARRIED COUPLE. THE LIMIT APPLIES TO SSI AND MEDI-CAL ONLY

Mark All that Apply

☐ CHECKING ACCOUNT
GET BANK NAME AND ACCT#

☐ SAVINGS ACCOUNT
GET BANK NAME AND ACCT#

☐ CREDIT UNION
GET NAME AND ACCT#

☐ TRUST ☐ STOCKS / BONDS ☐ CHRISTMAS CLUB

☐ REAL ESTATE ☐ BURIAL PLOT ☐ LIFE INSURANCE

☐ CAR / MOTORCYCLE ☐ BOAT ☐ TRAILER

WILL / BURIAL

☐ YES ☐ NO
(Get copy of this information for the file)

TYPE: ____

WHEN ESTABLISHED: ____

VALUE: ____

CONSERVED

IS THE CLAIMANT CONSERVED? ☐ YES ☐ NO

CONSERVATOR NAME: ____

CONSERVATOR ADDRESS: ____

____

PHONE#: ____

MARITAL STATUS / CHILDREN

☐ SINGLE ☐ MARRIED (DATE: __________) ☐ SEPERATED (DATE: __________)

☐ DIVORCED (DATE: __________) ☐ ANNULLED (DATE: ____________)

☐ WIDOWED (DATE: __________)

CHILDREN? ☐ YES ☐ NO IF YES, HOW MANY? ________________________

EMERGENCY CONTACTS

NAME	NAME
STREET ADDRESS	STREET ADDRESS
CITY / STATE / ZIP CODE	CITY / STATE / ZIP CODE
TELEPHONE	TELEPHONE
RELATIONSHIP	RELATIONSHIP

OTHER CONTACTS

NAME	NAME
STREET ADDRESS	STREET ADDRSS
CITY / STATE / ZIP CODE	CITY / STATE / ZIP CODE
TELEPHONE	TELEPHONE
RELATIONSHIP	RELATIONSHIP

IDENTIFICATION

GET A COPY OF THE FOLLOWING FOR FILE:

PHOTO ID

SSA CARD

MEDI- CAL CARD

OTHER ID

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Budget Worksheet

Client Name: ______________________________

SSN / TRUST: ______________________________

Effective Date: ______________________________

SSI (T16): ______________________

SSA (T2): ______________________

OTHER: ________________________

TOTAL: ________________________

TYPE	AMOUNT	DATE / FREQUENCY	VENDOR NAME & ADDRESS
Rent			
P&I			
Electricity			
GAS			
Other/Misc			
Other/Misc			
Payee Fee			

TOTAL: __________

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

I understand and agree with the following.

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 ______________________________ to be my representative payee.

My Right to Appeal

I understand that 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 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 (Number and Street, City, State and ZIP Code)	Address (Number and Street, City, State and ZIP Code)

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Consent to Release Information

To: Benefits Management Corporation and Living in Familiar Environments

Name:______________________________ Date of Birth: ____________________

SSN: ______________________________

I hereby give my consent to **Benefits Management Corp / L.I.F.E.** to obtain and/or exchange information for the purpose of either planning for my well-being and/or assuring my continuing eligibility for Social Security benefits.

I also hereby give my consent to **BMC / L.I.F.E.** to obtain and/or exchange information regarding the item(s) below for the purpose of planning for my well-being.

- ☐ Social Security Number
- ☐ Account Ledger
- ☐ Current Monthly SSA/SSI
- ☐ Bank Account
- ☐ Burial Trust
- ☐ Medi-Cal
- ☐ Utility Bills
- ☐ Wages/Employment Record
- ☐ Address/Living Arrangement
- ☐ O.H.S. Plan / Appointments
- ☐ Social History
- ☐ Other (explain below)

____

____

I am the individual, to whom the requested information/records applies, or the parent or legal guardian of a minor, or the legal guardian of a legally incompetent adult. I declare that I have examined all of 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 BMC / LIFE is not responsible if a person authorized to obtain information regarding my account does so with false pretenses and BMC / LIFE is not responsible for any effect to your benefits caused by releasing the requested information.

______________________________ Print Name	______________________ Date
______________________________ Signature of Claimant or Legal Guardian	______________________ Relationship (if not claimant)
______________________________ L.I.F.E. Staff Member	______________________ Date

Form Approved
OMB No. 0960-0623

WHOSE ***Records to be Disclosed***

NAME *(First, Middle, Last)*

SSN - -	Birthday *(mm/dd/yy)*

AUTHORIZATION TO DISCLOSE INFORMATION TO THE SOCIAL SECURITY ADMINISTRATION (SSA)

**** PLEASE READ THE ENTIRE FORM, BOTH PAGES, BEFORE SIGNING BELOW ****

I voluntarily authorize and request disclosure (including paper, oral, and electronic interchange)**:**

OF WHAT ***All my medical records;*** **also education records and other information related to my ability to perform tasks. This includes specific permission to release:**

1. **All records and other information regarding my treatment, hospitalization, and outpatient care for my impairment(s) *including*, and not limited to:**
   - Psychological, psychiatric or other mental impairment(s) (excludes "psychotherapy notes" as defined in 45 CFR 164.501)
   - Drug abuse, alcoholism, or other substance abuse
   - Sickle cell anemia
   - Records which may indicate the presence of a communicable or noncommunicable disease; and tests for or records of HIV/AIDS
   - Gene-related impairments (including genetic test results)
2. **Information about how my impairment(s) affects my ability to complete tasks and activities of daily living, and affects my ability to work.**
3. **Copies of educational tests or evaluations, including Individualized Educational Programs, triennial assessments, psychological and speech evaluations, and any other records that can help evaluate function; also teachers' observations and evaluations.**
4. **Information created within 12 months after the date this authorization is signed, as well as past information.**

FROM WHOM

- **All medical sources** (hospitals, clinics, labs, physicians, psychologists, etc.) including mental health, correctional, addiction treatment, and VA health care facilities
- All educational sources (schools, teachers, records administrators, counselors, etc.)
- Social workers/rehabilitation counselors
- Consulting examiners used by SSA
- Employers, insurance companies, workers' compensation programs
- Others who may know about my condition (family, neighbors, friends, public officials)

THIS BOX TO BE COMPLETED BY SSA/DDS (as needed) Additional information to identify the subject (e.g., other names used), the specific source, or the material to be disclosed:

TO WHOM **The Social Security Administration and to the State agency authorized to process my case** (usually called "disability determination services"), **including contract copy services, and doctors or other professionals consulted during the process.** [Also, for international claims, to the U.S. Department of State Foreign Service Post.]

PURPOSE Determining my **eligibility for benefits**, including looking at the combined effect of any impairments that by themselves would not meet SSA's definition of disability; and whether I can manage such benefits.

☐ Determining whether I am **capable of managing benefits ONLY** (check only if this applies)

EXPIRES WHEN This authorization is good for 12 months from the date signed (below my signature).

- I authorize the use of a copy (including electronic copy) of this form for the disclosure of the information described above.
- I understand that there are some circumstances in which this information may be redisclosed to other parties (see page 2 for details).
- I may write to SSA and my sources to revoke this authorization at any time (see page 2 for details).
- SSA will give me a copy of this form if I ask; I may ask the source to allow me to inspect or get a copy of material to be disclosed.
- **I have read both pages of this form and agree to the disclosures above from the types of sources listed.**

PLEASE SIGN USING BLUE OR BLACK INK ONLY

INDIVIDUAL authorizing disclosure

SIGN ▶

IF not signed by subject of disclosure, specify basis for authority to sign

☐ **Parent of minor** ☐ **Guardian** ☐ **Other personal representative (explain)**

(Parent/guardian/personal representative sign here if two signatures required by State law) ▶

Date Signed	Street Address		
Phone Number (with area code)	City	State	ZIP -

WITNESS *I know the person signing this form or am satisfied of this person's identity:*

SIGN ▶

IF needed, second witness sign here (e.g., if signed with "X" above)

SIGN ▶

Phone Number (or Address)	Phone Number (or Address)

This general and special authorization to disclose was developed to comply with the provisions regarding disclosure of medical, educational, and other information under P.L. 104-191 ("HIPAA"); 45 CFR parts 160 and 164; 42 U.S. Code section 290dd-2; 42 CFR part 2; 38 U.S. Code section 7332; 38 CFR 1.475; 20 U.S. Code section 1232g ("FERPA"); 34 CFR parts 99 and 300; and State law.

Explanation of Form SSA-827, "Authorization to Disclose Information to the Social Security Administration (SSA)"

We need your written authorization to help get the information required to process your claim, and to determine your capability of managing benefits. Laws and regulations require that sources of personal information have a signed authorization before releasing it to us. Also, laws require specific authorization for the release of information about certain conditions and from educational sources.

You can provide this authorization by signing a form SSA-827. Federal law permits sources with information about you to release that information if you sign a single authorization to release all your information from all your possible sources. We will make copies of it for each source. A covered entity (that is, a source of medical information about you) may not condition treatment, payment, enrollment, or eligibility for benefits on whether you sign this authorization form. A few States, and some individual sources of information, require that the authorization specifically name the source that you authorize to release personal information. In those cases, we may ask you to sign one authorization for each source and we may contact you again if we need you to sign more authorizations.

You have the right to revoke this authorization at any time, except to the extent a source of information has already relied on it to take an action. To revoke, send a written statement to any Social Security Office. If you do, also send a copy directly to any of your sources that you no longer wish to disclose information about you; SSA can tell you if we identified any sources you didn't tell us about. SSA may use information disclosed prior to revocation to decide your claim.

It is SSA's policy to provide service to people with limited English proficiency in their native language or preferred mode of communication consistent with Executive Order 13166 (August 11, 2000) and the Individuals with Disabilities Education Act. SSA makes every reasonable effort to ensure that the information in the SSA-827 is provided to you in your native or preferred language.

IMPORTANT INFORMATION, INCLUDING NOTICE REQUIRED BY THE PRIVACY ACT

All personal information collected by SSA is protected by the Privacy Act of 1974. Once medical information is disclosed to SSA, it is no longer protected by the health information privacy provisions of 45 CFR part 164 (mandated by the Health Insurance Portability and Accountability Act (HIPAA)). SSA retains personal information in strict adherence to the retention schedules established and maintained in conjunction with the National Archives and Records Administration. At the end of a record's useful life cycle, it is destroyed in accordance with the privacy provisions, as specified in 36 CFR part 1228.

SSA is authorized to collect the information on form SSA-827 by sections 205(a), 223(d)(5)(A), 1614(a)(3)(H)(i), 1631(d)(1) and 1631 (e)(1)(A) of the Social Security Act. We use the information obtained with this form to determine your eligibility, or continuing eligibility, for benefits, and your ability to manage any benefits received. This use usually includes review of the information by the State agency processing your case and quality control people in SSA. In some cases, your information may also be reviewed by SSA personnel that process your appeal of a decision, or by investigators to resolve allegations of fraud or abuse, and may be used in any related administrative, civil, or criminal proceedings.

Signing this form is voluntary, but failing to sign it, or revoking it before we receive necessary information, could prevent an accurate or timely decision on your claim, and could result in denial or loss of benefits. Although the information we obtain with this form is almost never used for any purpose other than those stated above, the information may be disclosed by SSA without your consent if authorized by Federal laws such as the Privacy Act and the Social Security Act. For example, SSA may disclose information:

1. To enable a third party (e.g., consulting physicians) or other government agency to assist SSA to establish rights to Social Security benefits and/or coverage;
2. Pursuant to law authorizing the release of information from Social Security records (e.g., to the Inspector General, to Federal or State benefit agencies or auditors, or to the Department of Veterans Affairs(VA));
3. For statistical research and audit activities necessary to ensure the integrity and improvement of the Social Security programs (e.g., to the Bureau of the Census and private concerns under contract with SSA).

SSA will not redisclose without proper prior written consent information: (1) relating to alcohol and/or drug abuse as covered in 42 CFR part 2, or (2) from educational records for a minor obtained under 34 CFR part 99 (Family Educational Rights and Privacy Act (FERPA)), or (3) regarding mental health, developmental disability, AIDS or HIV.

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 possible reasons why information you provide us may be used or given out are available upon request from any Social Security Office.

PAPERWORK REDUCTION ACT

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 10 minutes to read the instructions, gather the facts, and answer the questions. **SEND OR BRING IN 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 Blvd., Baltimore, MD 21235-6401. Send **only** comments relating to our time estimate to this address, not the completed form.

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)

COLLECTION AND USE OF INFORMATION ON YOUR CONSENT FORM— PRIVACY ACT NOTICE

The Social Security Administration is authorized to collect the information on your consent form under sections 205(a) and 1631(e) of the Social Security Act, as amended (42 U.S.C. 405 and 42 U.S.C. 1383(e)). Giving us the information on this form is voluntary. You do not have to do it but benefits may not be payable unless you give us this information.

The Social Security Administration will use this form to get information to decide eligibility for payments. We may routinely give out the information obtained without your consent if:

1. We need to get more information to decide eligibility for benefits;
2. An agency needs this information to decide eligibility for a health or income program such as Supplemental Security Income (SSI), State supplementary payments, food stamps, Medicaid, energy assistance, Veterans benefits, railroad unemployment insurance, or Basic Educational Opportunity Grants;
3. A Federal law requires that we give out this information;
4. Your congressman or the President's Office needs this information to answer questions you ask them;
5. Someone needs this information to do statistical research or audit reports for us related to the Social Security programs; or,
6. The Department of Justice needs the information to represent the Federal Government in a court suit related to an SSA program.

These and other reasons why information about you may be used or given out are explained in the Federal Register. If you would like more information about this, get in touch with any Social Security office.

*U.S. Government Printing Office: 1998 - 433-335/80148

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Representative Payee Acknowledgement

I understand that by signing and submitting these documents, the Social Security Administration (SSA) may determine it necessary for me to have a representative payee and may appoint Benefits Management Corporation/Living in Familiar Environments to serve as such.

Note: On page 7 of the Social Security Administration's Guide for Organizational Representative Payees, SSA states, "SSA will never appoint a representative payee solely for a beneficiary's convenience or personal preference".

______________________________	______________________________
Client Signature	Date
______________________________	______________________________
BMC / LIFE Staff Member	Date

CLIENT AGREEMENT – Processes and Procedures

Supplemental Security Income (SSI) is a needs-based benefit. That means that the amount of money for which you are eligible is based on three things:

1. Your living arrangements
2. Other income/benefits you may receive
3. Your total resource, which are things you own. For example; bank accounts, stocks, bonds, homes, vehicles, jewelry, etc.

Benefits Management Corporation (BMC) and Living In Familiar Environments (L.I.F.E.) **will not** be held responsible for any overpayments due to your failure to notify our office of changes. **Notification of changes must be made in writing.** This can be done in person by visiting our office, by fax, email, or by mailing a **signed** letter to BMC/L.I.F.E.

IT IS VERY IMPORTANT TO NOTIFY US WITHIN 10 DAYS IF ANY OF THE ITEMS BELOW OCCUR.

RESIDENCE

- You move from your residence
- Someone permanently moves into or out of your residence
- You enter jail or prison (BMC/L.I.F.E. does not accept collect phone calls from jail or prison)
    - **Note: If you fail to notify us by phone, email, or mail and money is issued for rent, utilities and other expenses, BMC/L.I.F.E. is not responsible for any overpayment that occurs.**
- You change your phone number
- You enter or leave a hospital or skilled nursing facility.
- You leave the state of California.

RESOURCES

- The amount of alimony or child support you receive changes
- You inherit or are given money
- You open or close a bank account, and if you receive interest on the account
- The amount of any benefit checks you receive directly changes
- You receive money from another source (VA, Railroad Retirement, or pension)
- Your benefit from another source stops
- You start or stop working
    - **Note: If you work, you must provide copies of your wage stubs to BMC/L.I.F.E. to submit to the Social Security Administration. If you do not provide copies of your wage stubs and are overpaid, BMC/L.I.F.E. will not be held responsible.**
- Purchase a burial plot or make burial arrangements
- Purchase a life insurance policy on yourself or someone else
- Buy or sell any auto, truck, boat, motorcycle, RV, etc.
- Buy or sell any real estate, including a house, condo or mobile home

WHAT HAPPENS DURING THE INTAKE INTERVIEW AT BENEFITS MANAGEMENT CORPORATION AND LIVING IN FAMILIAR ENVIRONMENTS?

1. At the time of intake, the BMC/LIFE representative can tell you when BMC/L.I.F.E. will **expect** to begin receiving your benefits.
   - If the intake is completed before the Social Security Administration's "cut off" date for the month (this is usually the second Friday of each month) BMC/L.I.F.E. should receive your next month's benefits.
   - If your benefits are in suspense (your benefits are stopped for some reason), BMC/L.I.F.E. will work to get your benefits reinstated as quickly as possible.
   - If you are a new claimant, BMC/L.I.FE., will contact the Social Security Administration regularly until your benefits are approved and the Social Security Administration begins distributing your benefits.

2. You will be told who your Account Manager is and you will be provided with the Account Manager's contact information. The Account Manager is the person you will speak with regarding your budget and account. You will need to notify your account manage in the event any changes occur; such as moving, living arrangements, and phone number.

3. Your Account Manager has a voicemail box and email for you to contact them. Your Account Manager will return your voicemail or email messages as soon as possible. The office lobby is open 7:30am to 4:00pm Monday through Friday and closed on all federal holidays. It is important to leave full details on your voicemail message. Always leave your first and last name, social security number, phone number where you can be reached, and detailed reason for your call. **PLEASE LEAVE ONLY ONE MESSAGE PER DAY AND ALLOW THE ACCOUNT MANAGER TIME TO RETURN YOUR CALL.** Leaving multiple messages will only delay your return call.

4. If possible, your budget is established at the time of the intake. If we are unable to establish a budget at the time of your intake, you will need to contact your Account Manager to do so before BMC/L.I.F.E. can release your funds. You will need to provide a copy of your rental agreement and bills that you would like BMC/L.I.F.E. to pay before payment can be made. **Note: You are responsible for paying your own telephone and cable bills.**

What Happens AFTER I Sign Up For BMC/L.I.F.E. Service?

1. If you need to speak to your Account Manager, call (866) 622-3098.

2. You must have an appointment to meet with your Account Manager. You can schedule an appointment by calling or emailing your Account Manager or speaking with the Front Counter Staff in our office. **Same day appointments will not be scheduled.**

3. Once your budget is set for the month, you must follow the spending plan that is in place for that month. Any requests to change your budget for the following month must be submitted at least 5 days before the last business day of the current month.

4. Personal and Incidental funds are included in your monthly budget. If you have additional funds available after your budgeted expenses are set, you may request to have a portion of those funds issued to you.

   - You must complete an Expenditure Request Form if you are requesting funds in excess of $250.

   - **You must give your Account Manager at least 24 hours to process your request. It is not possible to approve requests immediately.**

   - You are required to submit receipts to show how the funds outside of your set budget are spent.

5. You can receive your personal spending money via check mailed to your address or deposited to the L.I.F.E. Freedom Card (Debit Card). Rent and vendor checks are mailed directly to the person to whom the check is made payable.

6. Checks are mailed the day before their scheduled arrival. For example, if you are scheduled to receive a check on the first of the month, that check will be printed and mailed the afternoon before the first of the month.

7. You can have you utility bills mailed directly to one of the post office boxes possessed by BMC/L.I.F.E. for payment. Your name must be on the bill. **You are responsible for paying your own phone and cable bills.**

8. If you are homeless and do not have a mailing address, we encourage you to obtain a post office box. If you do not have a mailing address, we will recommend that you use the L.I.F.E. Freedom card to receive and use your personal spending money.

9. For your protection, you are the only person that can pick up your check. Vendor checks will not be released to clients. Vendor checks are mailed to the address BMC/L.I.F.E. has on file for that vendor.

10. BMC/L.I.F.E. is always closed the last business day off each month to prepare for the coming month.

11. BMC/L.I.F.E. observes all Federal holidays. If you are scheduled to receive a check on a holiday or a weekend, you should receive your check the day before that holiday.

I understand the above statements and I also understand the following:

1. If you do not receive your check, report it lost or stolen immediately. We will place a stop payment and reissue the check. It takes 45 days from the original check date to reissue another.

2. IT IS VERY IMPORTANT TO NOTIFY YOUR ACCOUNT MANAGER BEFORE THE LAST DAY OF THE MONTH IF YOU ARE PLANNING ON MOVING THE FOLLWING MONTH. IF YOU FAIL TO DO SO, YOUR RENT MIGHT NOT BE PAID CORRECTLY AND YOUR PERSONAL SPENDING CHECK MAY BE MAILED TO THE INCORRECT ADDRESS.

3. You are expected to be a good neighbor and responsible member of your community. We reserve the right to terminate payee services if we receive complaints that you've damaged property, are verbally or physically abusive to neighbors or other members of the community, or are appear to be chronically intoxicated or under the influence of drugs in public. Any funds remaining in your account will be returned to the Social Security Administration.

4. Benefits Management Corporation/Living in Familiar Environments is here to serve you and administer your benefits according to the Social Security Administration regulations. Benefits Management Corp/Living in Familiar Environments will terminate payee services if a client is physically or verbally abusive to BMC/L.I.F.E staff or other clients or damages BMC/L.I.F.E. property. Any funds remaining in your account will be returned to the Social Security Administration. Benefits Management Corporation and Living in Familiar Environments reserves the right to withhold a check or deposit from any client who appears to be intoxicated or under the influence of drugs. This policy is for our client's own protection.

Benefits Management Corporation and
Living in Familiar Environments
2640 Cordova Lane • Ranch Cordova, CA 95670
297 Commercial Street, Suite #700 • San Jose, CA 95112
www.webpayee.com * Phone (866) 622-3098 * Fax (866) 606-3248

I hereby acknowledge that I understand the Client Agreement and the Benefits Management Corporation (BMC) and Living In Familiar Environments (L.I.F.E.) procedures and received a copy for my records. I agree to abide by the reporting and procedure requirements to maintain my payee service with BMC and L.I.F.E.

__________________________________ __________________________________
Client Signature Date

__________________________________ __________________________________
BMC / LIFE Staff Member Date