The Organizer II, Inc.
Private Fiduciary / Representative Payee

197 Woodland Parkway Suite 104 #480
San Marcos, CA 92069
Office (760) 734-3769 · **Fax (760) 734-1142**
www.TheOrganizer2.com · E-Mail: info@organizer2.com

Instructions on filling out New Representative Payee Form

If the client has or does not have a payee and needs one, we can be their payee!

Please fill out **ALL** pages of this packet then faxed the completed pages back to our office. Or you can scan as a pdf and email it back to us.

- New Client Information Sheet.
- Representative Payee/Client Contract.
- Homeless Application Information sheet. (If applicable)
- Request & Authorization for Release of Information. (Form ROI)
- Advance Notification of Representative Payment. (Form SSA-4164)
- Social Security Consent for Release of Information. (Form SSA-3288)
- Physician's or Medical Officer's Statement of Patient's Capability to Manage Benefits. (Form SSA-787)
    - Social Security **REQUIRES** all **ORGINAL** Doctor's Letter's faxed directly to Social Security at (833) 950-3691. Fax us a copy with completed package to 760 734 1142
- Letters & Orders from Conservators Office (If applicable)
    - If the Client is conserved the above documents must be signed by the Public Conservators Office.
- Copy of current Identification Card.

If you have any questions, please call our office 760-295-3812. This is our administration phone number. **Please do not give** our administration number to a client!

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NEW CLIENT INFORMATION SHEET

Clear Form (Please fill out all area's that pertains to you)

NAME & GENERAL INFORMATION

Full Name:				Today's Date:	
	Last	First	M.I.		
Current Address:					
	Street Address			Apartment/Unit #	
	City		State	ZIP Code	
Phone:		Email:			
Social Security No:		Birthday:		City & State born in:	
Mothers Maiden Name:					

Are you?	Single ☐	Married ☐	Divorced ☐	Widowed ☐
Do you have your own bank account?	YES ☐	NO ☐	If yes, BA #:	Bank name:
Do you own a car?	YES ☐	NO ☐	If yes, Type/Year:	

SOURCE OF INCOME & LIVING SITUATION

SSI: $	SSA: $	SSDI: $	Pension/VA/Other: $		
Self ☐	Family ☐	Independent Living ☐	Skilled Nursing ☐	License Board & Care ☐	Homeless/Shelter ☐

OWN HOME OR RENT AND LOCATION OF PLACE

Landlord or Company Name:		License #	
Address:			
	Street Address		Apartment/Unit #
	City	State	ZIP Code
Phone:		Amount of Rent Paid: $	
Home owner?:	YES ☐ NO ☐		

MONTHLY EXPENSES

Rent: $		Cell Phone: $		Gas/Electricity: $		Cable: $	
Auto: $		OTHER: $		OTHER: $		OTHER: $	
Home owner: $							

CURRENT PAYEE STATUS

Do you currently have a payee?	YES ☐	NO ☐	
Name:		Phone No:	
Relationship:			

IF YOU HAVE A CURRENT SOCIAL WORKER, LEGAL GUARDIAN AND OR CASE MANAGER

Do you currently have a Social Worker or Case Manager?	YES ☐	NO ☐		
If yes, what is their name:		Phone No:		
Do you have a court appointed Legal Guardian:	YES ☐	NO ☐	Start Date:	
If yes, what is their name:		Phone No:		
Their Address		Relationship:		

SIGNATURE AND DATE OF APPLICATION

SIGNATURE:		TODAY'S DATE:	

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REPRESENTATIVE PAYEE/CLIENT CONTRACT

I, _____ have discussed my needs with The Organizer II Inc. and I agree to have The Organizer II, Inc. serve as my organization representative payee for my Social Security benefits. I understand there is a monthly fee for services set annually my Social Security Administration.

I will do the following:

I will be clean and sober when I conduct business by phone and person.

I will treat the staff at The Organizer II Inc. with courtesy and respect.

I must set up an appointment to conduct business in person.

The methods that I can receive personal spending funding are by either a check or prepaid debit card.

I am allowing The Organizer II, Inc. will deposit any checks payable to me into a trust account on my behalf and utilize in my best interest.

The Organizer Inc. will treat me with respect, courtesy and dignity.

Your funds we receive on your behalf are always used to fill your needs for food, housing, clothing, medical care and personal comfort items.

You must report any changes or events to Social Security Administration and The Organizer II Inc. that may affect your eligibility or change of amount of payments from Social Security Administration.

All required reports from Social Security Administration must be answer including money that has been spent/saved.

Any funds, if any, are saved for future needs.

The Organizer II Inc. will return any funds to Social Security Administration for example, like changing of payee.

I understand that if I fail to comply with these rules, The Organizer II Inc. may request Social Security Administration to remove The Organizer II Inc. as my representative payee.

Beneficiary Signature: _____ Date: _____

Organization Signature: _____ Date: _____

HOMELESS APPLICATION

INFORMATION SHEET

The Organizer II Inc.

Reset

FAILURE TO FILL OUT THIS APPLICATION WILL RESULT IN YOU NOT GETTING YOUR MONEY.

My name is _____Social Security #_____ _____ _____

Date of Birth:_____Place of Birth:_____

I would like my weekly / monthly money to be sent to (one) of the following for me to pick up.

Select State

☐ Brother Benos Foundation
3260 Production Ave.
Oceanside, CA 92058 Phone: 760 439-1244

☐ Father Joe's Village
3350 E Street
San Diego, CA 92101 Phone: 619 446-2100

☐ Interfaith Community Services
550 W Washington Ave.
Escondido, CA 92025 Phone:760 504-9420

☐ Neil Good Day Center
299 17th Street
San Diego, CA 92025 Phone: 619 230-7390

☐ Rachels Women Center
759 Eighth Ave.
San Diego, CA 92101 Phone: 619 696-0873

☐ Uptown Faith Community Center
3725 30th St
San Diego, CA 92104 Phone: 619 281-8411

☐ Other: Relative, PO Box, etc.

Current phone number to contact me: _____ Own / family member

Select State

Social Services Dept:_____Phone:_____
Notes:

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REQUEST & AUTHORIZATION FOR RELEASE OF INFORMATION

I _____ request and authorize The Organizer II, Inc. Representative Payee Service and/or any of its authorized representatives, to act on my behalf as advocates. I agree that the information gathered may be shared with Resource Agencies, Medical Professionals, and Caregivers for my continuing well being.

Additionally, The Organizer II or it's representatives may discuss, and/or make financial decisions or monthly payment obligations on my behalf.

I waive any and all claims which may raise from my participation in the Program and release and hold harmless The Organizer II, Inc. and its representatives, this excludes over payments regarding SSA/SSI.

_____ _____
Signature Date

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 The Organizer II Inc. to be my representative payee.

My Right to Appeal

I have the right to appeal the 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.

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 of Street, City, State and ZIP Code)	Address (Number of Street, City, State and ZIP Code)

Form SSA-4164 (5/91) Destroy Prior Editions

Social Security Administration

Consent for Release of Information

Form Approved
OMB No. 0960-0566

Instructions for Using this Form

Complete this form only if you want us to give information or records about you, a minor, or a legally incompetent adult, to an individual or group (for example, a doctor or an insurance company). If you are the natural or adoptive parent or legal guardian, acting on behalf of a minor child, you may complete this form to release only the minor's non-medical records. We may charge a fee for providing information unrelated to the administration of a program under the Social Security Act.

NOTE: Do not use this form to:

- Request the release of medical records on behalf of a minor child. Instead, visit your local Social Security office or call our toll-free number, 1-800-772-1213 (TTY-1-800-325-0778), or
- Request detailed information about your earnings or employment history. Instead, complete and mail form SSA-7050-F4. You can obtain form SSA-7050-F4 from your local Social Security office or online at www.ssa.gov/online/ssa-7050.pdf.

How to Complete this Form

We will not honor this form unless all required fields are completed. An asterisk (*) indicates a required field. Also, we will not honor blanket requests for "any and all records" or the "entire file." You must specify the information you are requesting and you must sign and date this form. We may charge a fee to release information for non-program purposes.

- Fill in your name, date of birth, and social security number or the name, date of birth, and social security number of the person to whom the requested information pertains.
- Fill in the name and address of the person or organization where you want us to send the requested information.
- Specify the reason you want us to release the information.
- Check the box next to the type(s) of information you want us to release including the date ranges, where applicable.
- For non-medical information, you, the parent or the legal guardian acting on behalf of a minor child or legally incompetent adult, must sign and date this form and provide a daytime phone number.
- If you are not the individual to whom the requested information pertains, state your relationship to that person. We may require proof of relationship.

PRIVACY ACT STATEMENT

Section 205(a) of the Social Security Act, as amended, authorizes us to collect the information requested on this form. We will use the information you provide to respond to your request for access to the records we maintain about you or to process your request to release your records to a third party. You do not have to provide the requested information. Your response is voluntary; however, we cannot honor your request to release information or records about you to another person or organization without your consent. We rarely use the information provided on this form for any purpose other than to respond to requests for SSA records information. However, the Privacy Act (5 U.S.C. § 552a(b)) permits us to disclose the information you provide on this form in accordance with approved routine uses, which include but are not limited to the following:

1.To enable an agency or third party to assist Social Security in establishing rights to Social Security benefits and or coverage;
2.To make determinations for eligibility in similar health and income maintenance programs at the Federal, State, and local level;
3.To comply with Federal laws requiring the disclosure of the information from our records; and,
4.To facilitate statistical research, audit, or investigative activities necessary to assure the integrity of SSA programs.

We may also use the information you provide when we match records by computer. Computer matching programs compare our records with those of other Federal, State, or local government agencies. We use information from these matching programs to establish or verify a person's eligibility for Federally-funded or administered benefit programs and for repayment of incorrect payments or overpayments under these programs. Additional information regarding this form, routine uses of information, and other Social Security programs is available on our Internet website, www.socialsecurity.gov, or at your local Social Security office.

PAPERWORK REDUCTION ACT STATEMENT

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 3 minutes to read the instructions, gather the facts, and answer the questions. **SEND OR BRING THE COMPLETED FORM TO YOUR LOCAL SOCIAL SECURITY OFFICE. You can find your local Social Security office through SSA's website at** www.socialsecurity.gov**. Offices are also listed under U.S. Government agencies in your telephone directory or you may call 1-800-772-1213 (TYY 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.***

Social Security Administration

Consent for Release of Information

Form Approved
OMB No. 0960-0566

You must complete all required fields. We will not honor your request unless all required fields are completed. *(*Signifies a required field. **Please complete these fields in case we need to contact you about the consent form).*

TO: Social Security Administration

***My Full Name**	***My Date of Birth (MM/DD/YYYY)**	***My Social Security Number**

I authorize the Social Security Administration to release information or records about me to:

***NAME OF PERSON OR ORGANIZATION:** ***ADDRESS OF PERSON OR ORGANIZATION:**

***I want this information released because:**
We may charge a fee to release information for non-program purposes.

***Please release the following information selected from the list below:**
Check at least one box. We will not disclose records unless you include date ranges where applicable.

1. ☐ Verification of Social Security Number
2. ☐ Current monthly Social Security benefit amount
3. ☐ Current monthly Supplemental Security Income payment amount
4. ☐ My benefit or payment amounts from date _____ to date _____
5. ☐ My Medicare entitlement from date _____ to date _____
6. ☐ Medical records from my claims folder(s) from date_____ to date_____
   If you want us to release a minor child's medical records, do not use this form. Instead, contact your local Social Security office.
7. ☐ Complete medical records from my claims folder(s)
8. ☐ Other record(s) from my file (We will not honor a request for "any and all records" or "the entire file." You must specify other records; e.g., consultative exams, award/denial notices, benefit applications, appeals, questionnaires, doctor reports, determinations.)

I am the individual, to whom the requested information or record applies, or the parent or legal guardian of a minor, or the legal guardian of a legally incompetent adult. I declare under penalty of perjury (28 CFR § 16.41(d)(2004) that I have examined all the information on this form and it is true and correct to the best of my knowledge. I understand that anyone who knowingly or willfully seeking or obtaining access to records about another person under false pretenses is punishable by a fine of up to $5,000. I also understand that I must pay all applicable fees for requesting information for a non-program-related purpose.

***Signature:** _____ ***Date:** _____

****Address:** _____ ****Daytime Phone:** _____

Relationship (if not the subject of the record): _____ ****Daytime Phone:** _____

Witnesses must sign this form ONLY if the above signature is by mark (X). If signed by mark (X), two witnesses to the signing who know the signee must sign below and provide their full addresses. Please print the signee's name next to the mark (X) on the signature line above.

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)

PHYSICIAN'S/MEDICAL OFFICER'S STATEMENT OF PATIENT'S CAPABILITY TO MANAGE BENEFITS

PAPERWORK REDUCTION ACT:

This information collection meets the clearance requirements of 44 U.S.C. §3507, as amended by Section 2 of the Paperwork Reduction Act of 1995. You are not required to answer these questions unless we display a valid Office of Management and Budget control number. We estimate that it will take you about 10 minutes to read the instructions, gather the necessary facts, and answer the questions.

In replying, use this address:
SOCIAL SECURITY ADMINISTRATION

- Fax directly to San Marcos Social Security at (833) 950-3691

  & attach a copy with the application for the Organizer II

TELEPHONE NUMBER (Include Area Code)

DATE

SSA CONTACT

Privacy Act: This report is authorized by sections 205(a) and 205(j) of the Social Security Act, as amended (42 U.S.C. 405(a) and 405(j). While you are not required to respond, your cooperation will help us decide whether any Social Security benefits that may be due should be paid directly to the patient or to someone else on the patient's behalf. Your cooperation in completing and returning this statement will be appreciated.

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 these and other reasons why information you provide may be used or given out are available in Social Security Offices. If you want to learn more about this, contact any Social Security Office.

IDENTIFYING INFORMATION (SSA Only)
If different from patient

NAME OF WAGE EARNER OR SELF-EMPLOYED PERSON

SOCIAL SECURITY NUMBER

PATIENT'S NAME		PATIENT'S ADDRESS (Number and Street, City, State, and ZIP Code)
PATIENT'S SOCIAL SECURITY NUMBER	PATIENT'S DATE OF BIRTH	

YOUR HELP IS NEEDED

The patient shown above has filed for or is receiving Social Security or Supplemental Security Income payments. We need you to complete the back of this form and return it to us in the enclosed envelope to help us decide if we should pay this person directly or if he or she needs a representative payee to handle the funds. **Please Note:** This determination affects how benefits are paid and has no bearing on disability determinations. Thank you for your help.

WHO IS A REPRESENTATIVE PAYEE

A representative payee is someone who manages the patient's money to make sure the patient's needs are met. The payee has a strong and continuing interest in the patient's well-being and is usually a family member or close friend.

WHO NEEDS A REPRESENTATIVE PAYEE

Some individuals age 18 and older who have mental or physical impairments are not capable of handling their funds or directing others how to handle them to meet their basic needs, so we select a representative payee to receive their payments. Examples of impairments which may cause incapability are senility, severe brain damage or chronic schizophrenia. However, even though a person may need some assistance with such things as bill paying, etc., does not necessarily mean he/she cannot make decisions concerning basic needs and is incapable of managing his/her own money.

PLEASE COMPLETE THE INFORMATION ON THE REVERSE OF THIS FORM

1. Date you last examined the patient _____ .

2. Do you believe the patient is capable of managing or directing the management of benefits in his or her own best interest?

By capable we mean that the patient:

- Is able to understand and act on the ordinary affairs of life, such as providing for own adequate food, housing, clothing, etc., and
- Is able, in spite of physical impairments, to manage funds or direct others how to manage them.

☐ Yes — If "Yes", please omit question 3, but be sure to sign and date the form.

☐ No — If "No", please provide a brief summary of the findings that led to this conclusion. Also, complete question 3.

☐ Unsure — If "unsure", please explain.

3. Do you expect the patient to be able to manage funds in the future (for example, the patient is temporarily unconscious)?

☐ Yes ☐ No

If yes, please explain.

NAME OF PHYSICIAN/MEDICAL OFFICER *(Please print.)*	TITLE
ADDRESS *(Number and street, City, State, and ZIP Code)*	TELEPHONE NUMBER *(Include Area Code)*

I declare under penalty of perjury that I have examined all 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 anyone who knowingly gives a false or misleading statement about a material fact in this information, or causes someone else to do so, commits a crime and may be sent to prison, or may face other penalties, or both.

SIGNATURE OF PHYSICIAN/MEDICAL OFFICER	DATE