Client Contract

Client Full Name: _____ DOB: _____
Social Security Number: _____
POA/Guardian Name:_____ Phone: _____
Address: _____

I, or my advocate, have discussed my needs with my POA/Guardian. I agree to have Thrive serve has my representative payee for my monthly Social Security, SSI, SSDI, Veteran benefits and/or any work-related income over $200 per month. In return for a fee charged at Social Security Administration's (SSA) regulated rate, I understand that Thrive will provide the following services for the accounts that I have disclosed to them:

- Deposit, monitor, and review all federal benefits received
- Ensure compliance with Federally mandated SSA regulations
- Develop budget plans to meet my financial goals
- Process payments and store records of my expenses
- Maintain up to date records with the SSA
- Monthly account reconciliation
- Provide annual reporting to SSA
- Upon request, issue reports outlining account activity and balances

Please note that many creditors will not allow Thrive to work on your behalf until they receive written or verbal communication from you, your POA, or Guardian. Thrive will assist you in this process.
Please have them mail monthly bills/statements to: Thrive Payee Services, PO Box 1387, Hendersonville, NC 28793

I agree to:

_____ comply with and work within the guidelines set forth by Thrive and the Social Security Administration

_____ receive an agreed upon amount of monthly spending.

I understand that if I fail to comply with this contract, Thrive may refuse to continue to serve as my representative payee.

_____ _____
Beneficiary/Guardian Signature Date

_____ _____
Witness Date

Monthly Expenses

Client Full Name: _____ DOB: _____

Landlord:
Name:
_____
Address:
_____
_____
Phone #:
_____
Amount Due:
_____

Water:
Name:
_____
Address:
_____
_____
Phone #:
_____
Amount Due:
_____

Cable:
Name:
_____
Address:
_____
_____
Phone #:
_____
Amount Due:
_____

Car Payment:
Name:
_____
Address:
_____
_____
Phone #:
_____
Amount Due:
_____

Electric:
Name:
_____
Address:
_____
_____
Phone #:
_____
Amount Due:
_____

* After all your bills have been paid, how do you prefer to receive your spending money? (Check one)
☐ Weekly?
☐ Monthly?

Phone:
Name:
_____
Address:
_____
_____
Phone #:
_____
Amount Due:
_____

Pharmacy:
Name:
_____
Address:
_____
_____
Phone #:
_____
Amount Due:
_____

Other:
Name:
_____

Address:

_____

_____

Phone #:

_____

Amount Due:

_____

Other:

Name:

_____

Address:

_____

_____

Phone #:

_____

Amount Due:

_____

Other:

Name:

_____

Address:

_____

_____

Phone #:

_____

Amount Due:

_____

Payee Referral Form

Thrive staff are a dedicated group of professionals that assist individuals experiencing mental health symptoms to thrive in the community of their choice. We appreciate your referral for our payee services. Please fill out the information below and our staff will contact you with the status of your referral.

Referral Source/Case Manager Name:_____
Agency:_____

Phone Number: _____ Date of referral: _____

Demographic Information:

_____

Last Name First Name Middle Name Maiden Name

_____

Date of Birth Place of Birth Mother's Maiden Name

_____

_____Cell phone Home phone Social Security Number

_____

Street Address

_____

City State Zip Code County

_____

Medicaid # Medicare # Other Insurance Name and policy number

Marital Status: ___Never Married ___Divorced ___Widowed ___Other

Do you have any children? Y / N If yes, how many and what ages? _____

Military or Railroad Service? Y / N

Have you ever used another Name or Social Security Number? Y / N

If yes, please list:

_____

Do you have a valid driver's license and are able to drive? Y / N

Are you your own legal guardian? Y / N

If not, who is the legal guardian? If DSS is involved, what is the history?

_____

_____

_____

Do you have a payee currently? Y / N Contact info:_____

If yes, why is there an interest in Thrive's services?

_____

Why do you require a payee? Is there a diagnosis impacting your ability to handle your finances?

_____

_____

_____

Please note- If you have never been assigned a Representative Payee or are currently managing your own funds then a Physician or Medical Supervisor must complete the form attached (Form SSA-787). This form must be returned with this referral packet.

Housing:
Is there stable housing in place? Y / N

If not, what are the circumstances?

_____

_____

Moved in the last 2 years? Y / N If yes, when? _____

Check the line(s) that best describes your housing:

___ Alone ___ With a relative ___ With someone else

___ In my home ___ In a board or care facility ___ In a public institution

___ In a private institution ___In a nursing home

Please list the names and relationships of anyone that lives in your home.

_____

_____

_____

Monthly Income:

SS: _____ SSI: _____ SSDI: _____ Employment: _____

Food Stamps: _____ Other: _____

If employed please answer the following:

Employer: _____ Start Date: _____

Address: _____ City/State/Zip: _____

Hourly Rate: _____ Number of Hours Per Week: _____ Avg. Weekly Pay: _____

Personal Banking Account Information:

Checking Account: Bank Name and Location: _____

Savings Account: Bank Name and Location: _____

Other Assets (Stocks, Bonds, 401K, Car, Life Insurance, Trusts, Pre-paid burials, etc):

_____
_____
_____
_____

Emergency Contact:

Name: _____ Relationship: _____

Address: _____

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

Needed Paperwork:

- Guardianship Paperwork if applicable
- Physician's/Medical Officer's Statement of Patient's capability to manage benefits (SSA-787) if applicable
- Client contract (original signature required)
- Consent to Request
- Monthly Expense Worksheet

Please review, sign, and return all documents to:
Thrive
PO Box 1387
Hendersonville, NC 28793
Phone: 828-697-1581 Fax: 828-697-4492 Email: payee@thrive4health.org

Thrive Payee Services
PO Box 1387 Hendersonville, NC 28793
Phone: (828) 697-1581 Fax: (828) 697-4492

Authorization and Consent for Disclosure

CLIENT NAME:_____ DOB:
_____

I authorize the following persons or organizations to disclose and/or receive information:

_____ Bank Records _____ Utility Bills _____ Medical Bills
_____ Legal _____ Tuition _____ Credit Card
_____ Insurance _____ Court Documents _____ Financial Needs
_____ Other _____ Other
_____

From/To: Thrive
Payee Services
PO Box 1387
Hendersonville, NC 28793

From/To:
_____
_____
_____

FOR THE PURPOSE OF: (The minimum of protected information will be disclosed to accomplish the purpose specified).
Coordination of Services Continuity of Care Financial Stability
Other: _____

I understand that this consent is subject to revocation by me at any time, and unless an earlier date is specified, this release will expire 12 months after the date specified below. I understand that I am giving my permission to the above-named provider or other named third party for disclosure of confidential records that may include health care records. I understand that I have the right to revoke, in writing, to the person who is in possession of my records, except to the extent that action has been taken in reliance thereon. A copy of this consent will accompany any disclosure, and a notation concerning persons or agencies to whom disclosure was made shall be included with my original records. I may also request to inspect a copy of the information to be used or disclosed. The person who receives the records to which this consent pertains may not re-disclose them to anyone else without my separate written consent, unless such recipient is a provider who makes a disclosure permitted by law.
I understand that information in my health record may include information relating to sexually transmitted diseases, AIDS/HIV and alcohol/drug abuse. I do NOT authorize the release of any of the following information (place a check on the line for those not authorized):

_____ Sexually Transmitted diseases _____ AIDS/HIV _____ Alcohol/Drug Abuse

I understand that I have the right to refuse to sign this Authorization for Disclosure of Information.

Client Signature: _____ Refused to sign

Date:_____

This consent expires on_____

Legally Responsible Person (required if other than person receiving services)

_____ Relationship to individual:

_____ Date: _____

Witnessed by: _____ Date: _____

REVOCATION

I Revoke the above Authorization of Information except to the extent that action has been taken prior to _____.

Signed: _____ Date: _____

Prohibition on Re-disclosure: This information has been disclosed to you from records protected by Federal confidentiality rules relating to health care services (42 CFR Part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by Federal Statutes. A general authorization for the release of medical or other information is not sufficient for this purpose. The Federal rule restricts any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient. Federal and state mandates rule that medical records are the property of the facility who compiled the medical record. This information may contain documentation of mental health information. It may be detrimental to a consumer's health and well-being to review this material without professional assistance. When direct consumer access is contemplated, consider consulting a person with professional training and experience related to the consumer's condition.