

Thompson Social Services, Inc.

39 S. Tulpehocken St. Pine Grove, PA 17963 | Ph# (570) 617-4944

313 W. Liberty St. Suite 203 Lancaster, Pa 17603

Demographics Information

Date of Request: _____/_____/_____

Name: _____

Other Names / Alias: _____

Address (No P.O. Box): _____

County of Residence: _____

Place of Birth (City/State/Country): _____

Mother's maiden name: _____

Are you a US Citizen? _____ Yes _____ No | If No, Status: _____

Social Security Number: _____ - _____ - _____

Date of Birth: _____/_____/_____

Home Number: (_____) _____ - _____ Cell Number: (_____) _____ - _____

What is the reason you receive SSI/SSDI (What is your medical diagnosis or disability?)

What is the reason you are unable to manage your own finances?

Family Information / Next of Kin

Kin 1 Name: _____ Relationship: _____

Address: _____

Phone #: (_____) _____ - _____

Kin 2 Name: _____ Relationship: _____

Address: _____

Phone #: (_____) _____ - _____

Are you married: _____ Yes _____ No

If Yes: Partners Name: _____

Do you have children: _____ Yes _____ No Number: _____

Reside with: (check one)

____ Alone

____ Facility

____ Relative/Friend

____ Other

____ Group Home/CLA

____ Personal Care Boarding Home

(Please list names and relationships of any persons living with you)

Name

Relationship

1) _____

2) _____

3) _____

4) _____

5) _____

(Attach additional sheets if more space is needed.)

Sources of Income and Monthly amounts

SSD \$ _____ SSI \$ _____ VA \$ _____ Payroll/Other \$ _____

Are you employed? _____ Yes _____ No

If yes, please complete the following:

Employer Name: _____

Employer Address: _____

Hours worked per week: _____ Days per week: _____ Rate of pay: _____

Do you receive food stamps? If so, how much monthly? \$ _____

Assets/Banking Information (PROVIDE MOST RECENT STATEMENT)

Please list any checking/savings accounts on which your name appears and attach current bank statements. Attach additional sheets if needed:

Bank: _____

Type of Account: _____ Account Number: _____

Bank: _____

Type of Account: _____ Account Number: _____

Do you have a burial account? _____ Yes (PROVIDE COPY) _____ No

If yes, Bank Name: _____ Account #: _____

Do you have a burial plot? _____ Yes (PROVIDE COPY) _____ No

If yes, where? _____

Insurance Information

Do you have a Life Insurance Policy? _____ Yes (PROVIDE COPY) _____ No

If yes, Insurance Co. Name: _____

Policy #: _____ Value: \$ _____

Health Insurance

Medical Assistance? _____ Yes _____ No

ACCESS #: _____

Medicare? _____ Yes _____ No

Part A Claim #: _____ Effective Date: ___/___/___

Part B Claim #: _____ Effective Date: ___/___/___

Any Other Insurance? _____ Yes _____ No

If Yes, Insurance Co. Name: _____

Policy #: _____ Value: \$ _____

Current Servicers

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

If yes, please provide Name and Address and a copy of the Court Appointment:

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

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

Case Manager: _____

Agency Name & Address: _____

Phone#:(_____) _____ - _____ Email: _____

ONCE YOU RECEIVE YOUR LETTER FROM SSA OR A CALL FROM US STATING WE HAVE BEEN CHOSEN TO BE PAYEE PLEASE CALL YOUR ELECTRIC/GAS/TRASH/ETC PROVIDERS AND HAVE YOUR BILLING ADDRESS CHANGED TO:

THOMPSON SOCIAL SERVICES, INC.
39 S. TULPEHOCKEN ST.
PINE GROVE, PA 17963

Please also contact your local County Assistance office and advise them that you have a new Organization handling your funds and that you would like to add our information to your account so we receive your renewal information and can keep you under asset limit if necessary. Provide them with the above information for our agency.

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AUTHORIZATION FOR RELEASE AND RECEIPT OF INFORMATION

I give permission for Thompson Social Services to communicate relevant information with the Social Security Administration, financial institutions, mental health/residential staff or other appropriate resources working and on behalf of me. That permission will remain in effect during the time that Thompson Social Services, Inc. is holding my funds.

(Client Signature)

(Date)

(Witness Signature)

(Date)

REQUEST FOR REPRESENTATIVE PAYEE SERVICES

I am requesting that Thompson Social Services, Inc. serve as Representative Payee for my SSA 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 understand that there is a fee for this service in accordance with Social Security Administration rules and regulations.

(Client Signature)

(Date)

(Witness Signature)

(Date)