Klamath & Lake Community Action Services
535 Market St. Klamath Falls OR 97601
(541) 882-3500 Fax (541) 882-3674
www.klcas.org

Dear Participant:

We would like to thank you for choosing Klamath and Lake Community Action Services to be your Representative Payee. We take your choice as both an honor and a privilege and try to meet your needs as they arise. We know that life does not come with a script and things can come up, that is one of the many reasons that we can be reached on a daily basis. Your needs are considered high priority and we try to address them as quickly as possible.

As a participant of the Klamath and Lake Community Action Services Representative Payee Program, you have access to multiple supportive services that we provide to help you become more financially stable. You can contact us to request more information or to request assistance for any of the following:

- On-time bill payment;
- Checks printed twice weekly;
- Assistance with obtaining a Birth Certificate;
- Assistance with obtaining a Social Security Card;
- Assistance with obtaining State ID;
- Assistance with applying for Section 8 Housing;
- Dedicated staff for processing utility assistance applications;
- Develop and maintain a budget that includes a savings plan for future needs;
- Optional Prepaid Debit Card
- Free on-site Notary Service;
- Free check cashing at our local bank branch;
- Free loading service of prepaid phone cards;
- Flexible personal spending checks;
- Ease of anxiety or tension with managing one's own money; and
- Assistance with negotiating:
    - Rent/ deposit;
    - Utility deposits;
    - Credit/ debit accounts;
    - Financial assistance program access; and/or
    - Flexible payment options.

Thank you again for choosing the Klamath and Lake Community Action Services Representative Payee Program, we look forward to a strong and lasting relationship with you. You can contact us over the phone at 541-882-3500, or by email at tashab@klcas.org or cortneyg@klcas.org or by text at 541-539-4006 if you have any questions, concerns, to report changes or to access any of the services listed above. Our team is available Monday through Friday from 8:00 am to 5:00 pm.

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Dear _____,

Thank you for contacting us regarding your interest in having KLCAS serve as your Representative Payee.

Below is a list of documents that we will need you to submit to ensure the process of becoming a Rep Payee Particpant is successful. If an item on the list does not pertain to you, do not worry about bringing it in.

- ☐ Identification
- ☐ Birth Certificate
- ☐ Social Security Card
- ☐ Rental Agreement
- ☐ All Utility Bills
- ☐ Checking/Savings Account Information
- ☐ All Credit Cards
- ☐ Credit Card Statements
- ☐ All Passwords or Passcodes for online account access
- ☐ Paystubs, W-2's, 1099's
- ☐ Current Year Award Letter
- ☐ All Medical Documentation
- ☐ SNAP benefit letter
- ☐ All Partnering Agency Information (KBBH, APD, DDS, Mentor, etc.)
- ☐ Life/Burial Insurance Information
- ☐ Stock/Bonds or other Asset Information
- ☐ Employer Information
- ☐ Emergency Contact Information

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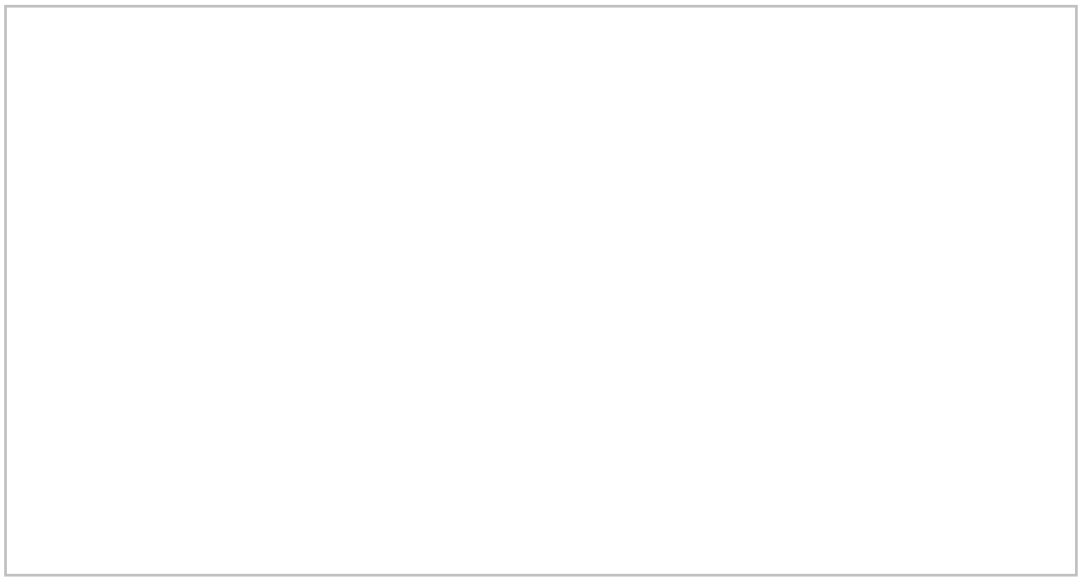
Identification and Social Security Card

Date: _____ Case #: _____

Participant Name:

_____



State/Tribe issued Identification Card or Driver's License

Social Security Card

klamath & lake community Actionservices
REPRESENTATIVE PAYEE SERVICES

New Participant Intake

KLCAS
535 Market St
Klamath Falls Or 97601
Phone: 541-882-3500
Fax: 541-882-3674

Date: _____ **Case #:** _____

First Name: _____ **Last Name:** _____

Physical Address: _____

Mailing Address: _____

Date of Birth: _____ **SSN:** _____ **Contact #:** ( ) -

Gender: ☐ F ☐ M **Veteran:** ☐ Yes ☐ No **Ethnicity:** *Hispanic* ☐ Yes ☐ No

Education: *Highest level completed* _____ **Race:** _____

Mother's Maiden Name: _____ **Father's Name:** _____

Place of Birth: _____ **Married:** ☐ Yes ☐ No

Spouse's Name: _____

Spouse's Address (if different): _____

Family Size: _____

Name: _____ **Relationship:** _____

Name: _____ **Relationship:** _____

Name: _____ **Relationship:** _____

Name: _____ **Relationship:** _____

Emergency Contact: _____

Address: _____

Phone #: ( ) -

Relationship: _____

Were you recently released from an institution or incarceration? ☐ Yes ☐ No

If yes, when? _____ **Where were you released from?** _____

Medical Diagnosis: _____

What type of medical insurance do you have? _____

Benefit Type:

☐ SSI	$	☐ SSDI	$	☐ VA	$	☐ Other:	
☐ TANF	$	☐ SNAP	$	☐ RRB	$		$

Employer Name: _____

Primary Care Physician: _____ **Contact #:** ( ) -

Signature: _____ **Date:** _____

Notes: _____

_____

Referring Agency ☐ Yes ☐ No

Name of Referring Agency: _____

Caseworker: _____ **Contact #:** ( ) -

Other Caseworker(s): _____

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REPRESENTATIVE PAYEE SERVICES

Income/Assets

Date: _____ Case #: _____

Participant Name:_____

Wages ☐ Check box if unemployed

Employer Name: _____
Employer Address: _____
Phone Number: _____ Supervisor: _____
Fax Number: _____
Start Date: _____ Starting Hourly Wage: $ _____
Hours Worked Weekly: _____
End Date: _____ Ending Hourly Wage: $ _____
Pay Cycle: _____ (weekly, bi-weekly, etc.)
Job Title: _____
Duties: _____

Assets

Checking Account: ☐ Yes ☐ No
Name of Financial Institution: _____
Account Holder Name: _____
Account number: _____ Account Balance: $ _____

Savings Account: ☐ Yes ☐ No
Name of Financial Institution: _____
Account Holder Name: _____
Account number: _____ Account Balance: $ _____

Burial/Life Insurance Account: ☐ Yes ☐ No
Name of Financial Institution: _____
Account Holder Name: _____
Account number: _____ Account Balance: $ _____

Stocks: ☐ Yes ☐ No
Name of Financial Institution: _____
Account Holder Name: _____
Account number: _____ Account Balance: $ _____

Bonds: ☐ Yes ☐ No
Account Holder Name: _____
Account number: _____ Account Balance: $ _____

Other Assets: ☐ Yes ☐ No
Description: _____ Value: $_____
Description: _____ Value: $_____

Notes:

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To Our Participants: We can help you better if we are able to work with other agencies that know you and your family. By signing this form, you are giving permission for these organizations to share information about your situation.
Your Name and Date of Birth:

_____

Purpose: The information received will be used to evaluate my situation and to plan for and coordinate services for my family for other purposes as specified: _____

I authorize any of the following individuals or agencies that I have initialed below to share and exchange information about me or my family and my circumstances with one another for the purpose described above:

ENTIRE FIRST COLUMN Recommended		
Initial:	**Initial:**	**Initial:**
_____ **KLCAS:** Homeless Prevention, Family Support & Connections, Energy Assistance, and Representative Payee.	_____ Dept. of Justice (Child Support)	_____ Police Department
_____ **State of Oregon, Department of Human Services:** Self-Sufficiency, Seniors & People with Disabilities, Vocational Rehabilitation, Child Welfare.	_____ Legal Aid Services of Oregon	_____ County Sheriff Department
_____ **Klamath/Lake:** Early Childhood Intervention, Klamath Family Head Start, Healthy Families America, OCDC, school district.	_____ Klamath Works	_____ Parole and Probation
_____ **Klamath Tribal**	_____ Lutheran Community Services	_____ Thrive Church
_____ **Landlord**_____	_____ Oregon Employment Department	_____ St. Vincent de Paul
_____ **Klamath Housing Authority**	_____ SOCO Development	_____ Gospel Mission
_____ **Social Security Administration**	_____ Klamath Adult Learning Center	_____ Marta's House
_____ **Dept. of Veteran's Affairs**	_____ Goodwill	
_____ **IRS**	_____ WIC	_____ Employer/Potential Employers
_____ **Reach**	_____ Hope Pregnancy Center	_____ Other:_____
_____ **Mentor Oregon**	_____ Klamath Tribal Health	
_____ **Connections DBA SORB Services**	_____ County Health Department	**Initial:** **Utility Companies**
_____ **Developmental Disability Services**	_____ Lake County Crisis Center	_____ Avista
_____ **Spokes**	_____ Hospital	_____ Pacific Power
	_____ Sky Lakes Outpatient	_____ Spectrum Cable
	_____ Cascade Health Alliance	_____ Dish
	_____ Drug Court-State of Oregon	_____ Direct TV
	_____ Klamath Basin Behavioral Health	_____ Sprint
	_____ Dragonfly Transformations	_____ US Cellular
	_____ Best Care Treatment Services	_____ City Water
	_____ Lutheran Community Services	_____ Sprint
	_____ Translink(Medical Bus)	_____ Waste Management
	_____ Medical Provider :_____	
	_____ Dental Provider :_____	_____ Other: _____
	_____ Child Care Provider: _____	_____ Other: _____
		_____ Other: _____
	_____ Other: _____	_____ Other: _____
	_____ Other : _____	

This permission is valid for 24 months from the date of the signature.
I can cancel this at any time; I must do so in writing. I understand that the cancellation will not affect any information that was already released before cancellation. I understand that information about my case is confidential and protected by state and federal law. I approve of the release of this information. I understand what this agreement means. I am signing on my own and have not been pressured to do so.

_____ _____Parent _____Guardian _____Legal Custodian
Signature Date

_____
Representative Payee Signature Date

To those receiving information under this authorization: State and Federal laws protect the information disclosed to you. You are not authorized to release it to any agency or person not listed on this form without the specific written consent of the person to whom it pertains, unless authorized by other laws.

This is a true copy of the original authorization document _____
(Agency Staff) Date

I, (please print name) _____, understand that the issuance of this prepaid debit card from KLCAS is my responsibility. I understand that in signing this document, I was explained in detail that the debit card issued will be reloaded based on my budget. **I understand that the loading of my card will take 2-3 business days, and for special check requests, I may not see that deposit until the end of the week.**

- I understand that the first card I am issued is free of charge.
- I understand that if I lose this card I will get **ONE** free replacement card within a 12 month period.
- I understand that if I lose the second card issued to me, there will be a $5 replacement fee for the next card issued.
- I also understand that KLCAS has the right to review and determine to issue paper checks IF I have lost more than 3 prepaid cards in a 12 month period.
- I understand that anytime I lose a card I need to **immediately** call KLCAS and speak to a Representative Payee team member.
- I understand that in not letting KLCAS know I have lost the card, any funds missing from that card from the time I lost it to the time I report it, is my responsibility, **NOT** the responsibility of KLCAS.
- I understand that I was explained the process to make my own cardholder account login to see my balances, and reset my PIN number in the event that I forget it.
- I was given the website address (https://www.usbankfocus.com), and given an instruction sheet for the first time log in.

The prepaid debit card issued to me will also have a PIN number assigned to it. I understand that it is my responsibility to remember my PIN Number and that in the event that I forget what it was it is important that I reset my PIN number by logging into my account that I set up, or by calling (888) 863-0681 for assistance.

I am signing this with full understanding of the program, policy set in place by KLCAS, and all questions I had being answered before my card is issued to me.

Participant Name (Printed):_____Date:_____

Participant Signature: _____ Client #:_____

Representative Payee Name (Printed):_____Date:_____

Representative Payee Signature: _____
Card #_____ 10 digit lookup # _____

535 Market Street, Klamath Falls, OR 97601 541.882.3500 866.665.6438 541.882.3674 fax

Rep Payee Prepaid Debit Card Info

First Name: _____

Last Name: _____

Physical Address: _____

_____

_____

Birth Date: _____

US Citizen Yes ☐ No ☐

Social Security Number _____

State of Residence: _____

10 digit Look UP # _____