HALO-SC, Incorporated

Post Office Box 71, Little Mountain, SC 29075
803-673-4671

RELEASE TO OBTAIN AND DISCLOSE INFORMATION

I/We, _____ authorize HALO-SC, Incorporated to obtain and disclose pertinent information from my/our records to/from:

The purpose of my/our request is:

TO DISCLOSE INFORMATION ABOUT MY FINANCES

I/We authorize the release of information:

___ For one time only (Within 90 days)

___ For up to one year

_X_ For as long as HALO-SC, Incorporated serves as my Representative Payee.

I understand that my records are protected under the Federal Confidentiality Regulation and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I understand that I may revoke this consent at any time, provided that action has not been taken in reliance upon this expiration date or upon release of the information. The nature of this consent form has been explained to me/us and I/We understand its contents.

Client Signature(s)

_____ Date: _____

_____ Date: _____

Other Signature: _____ Date: _____

Relationship to Client(s): _____

Signature of Witness: _____ Date: _____

Signature of Counselor: _____ Date: _____

Revised 10/18/2023

Representative Payee Fact Sheet

Name:_____ Social Security Number (SSN): _____-_____-_____

VA Claim Number: _____

Address: _____ Date of Birth: _____

City, State, Zip Code: _____

City, State of Birth: _____ Mother Maiden Name: _____

Cell Phone or Telephone Number: _____ Father's Name:_____

How Long at Current Address: _____ Name of Last Payee: _____

Why are you changing Representative Payee's? _____

_____

Are your basic living expenses being met now? ___ Yes ___ No

Referral Source	**Marital Status**	**Race**
Social Security Friend/Family Case Worker DSS Internet Telephone Book	Single Married Divorced Widowed Living Together	Caucasian African American Asian American Hispanic/Mexican

Dependents Information:

How Many Children/Dependents: _____

Do they live with you? _____ Yes _____ No

Names:

_____ Age: _____

_____ Age: _____

_____ Age: _____

Monthly Income	SSA:
(from all sources)	SSI:
	VA:
	Other:
	TOTAL of Income:

HALO-SC, Incorporated

Contract for Representative Payee Clients

I have discussed my financial needs with my counselor at HALO-SC, Incorporated. I agree to have HALO-SC, Incorporated serve as my representative payee for Veterans Benefits, Social Security and/or SSI payments.

I will:

- Be clean and sober when I come or call the office to conduct business
- Treat staff with courtesy and respect
- Come to conduct business only when I have called and arranged an appointment Receive $_____ for my spending money _____ as agreed.

In the event of a financial emergency, I will contact HALO-SC, Incorporated and speak with my counselor about my emergency. I will provide receipts for anything that I have to purchase in the event of an emergency.

In the event that I choose to change my payee to someone else then decide to return to HALO-SC, Incorporated within a six-month period, I will pay a reinstatement fee of $50.00 to HALO-SC, Incorporated. This money will be paid either up front or out of my first Veteran, Social Security, and/or SSI check that HALOSC, Incorporated receives.

I/We agree (s) to the following monthly service charge as established by Social Security Administration, which currently is a fee of up to 10 percent of the total monthly benefits from beneficiaries.

HALO-SC, Incorporated will:

- Treat me with courtesy and respect.
- Be available to meet with me at scheduled appointments.
- Use funds received on my behalf to meet my current needs for basic living expenses.
- Report to Social Security Administration any events that may affect my eligibility for payments or payment amounts.
- Account to Social Security any unspent funds, if any, in a way that clearly show the funds belong to me.
- Return to Social Security any funds that have been saved for me (in the event of a change in representative payee) or that were sent for my benefit but which I am not entitled.

Beneficiary Signature: _____ Date: _____

Rep. Payee Signature: _____ Date: _____

Revised 10/18/2023

HALO-SC, Incorporated

PRIVACY POLICY REPRESENTATIVE PAYEE SERVICES

Halo-SC, Incorporated is committed to assuring the privacy of individuals and/or families who have contacted us for assistance. We assure you that all information shared both orally and in writing will be managed within legal and ethical considerations. Your "personal financial information", such as your total debt information, income, living expenses, and personal information concerning your financial circumstances, will be provided to creditor and possibly others with your specific authorization. Without this authorization in writing, information about you or your finances WILL NOT be released.

We may also use aggregated case file information for the purpose of evaluating our services, gathering valuable research information and designing future programs. In all other situations, your information may be released to appropriate individuals or agencies **ONLY UPON YOUR WRITTEN REQUEST or when our staff has been serviced by a valid subpoena.**

The following PRIVACY PRACTICES detail circumstances under which we will release your information to a third party.

1. We do not disclose any nonpublic personal information about our clients or former clients to anyone, except as permitted by law.
2. We may compile data and aggregate information that you give to us, but this information may not be disclosed in a manner that would personally identify you in any way.
3. We may disclose some or all the information that we collect, as described below, to creditors, or third parties that you have authorized who need this information in order for us to assist you after a counseling session.
4. We restrict access to nonpublic personal information about you to those employees who need to know that information to provide services to you. We maintain physical, electronic and procedural safeguards that comply with federal regulations to guard your nonpublic personal information.
5. We collect nonpublic personal information about you from the following sources:
    a. Information we received from you on our applications or other forms you provide;
    b. Information about your transaction with us, your creditors, or others.
6. We may disclose the following kinds of nonpublic information about you:
    a. Information we received from you on our applications or other forms, such as your name, address, social security number, assets, and income;
    b. Information about your transactions with us, your creditors, or others, such as your account balance, payment history, parties to transactions and credit card usage, and

RELEASE: **I hereby release HALO-SC, Incorporated to release all non-public information it obtains about me to (1) my creditors and (2) any third parties necessary to resolve the matter(s) discussed during my counseling session.**

I further RELEASE and authorize all my creditors to provide non-public information about me to HALO-SC, Incorporated.

_____ _____

Client Signature Date:

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Advance Notification of Representative Payment

Name of Beneficiary | Social Security Number

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 interest.

Choice of Representative Payee

SSA has selected HALO-SC, INCORPORATED to be my representative payee.

My Right To Appeal

I, , understand that I have the right to appeal SSA's decision that I need a payee. I also can appeal the choice of who will be the representative 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 of Beneficiary 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.

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1. Signature of Witness

_____

Address

_____

2. Signature of Witness

_____

Address

_____ Form SSA-4164