



114 Needham
Coleman, TX 76834

Payee Application

Phone: 325-625-4167
Fax: 325-625-3335

PAYEE APPLICANT

FirstName:	LastName:	MI:	Rent/Own:	Phone:
Social Security #	Date of Birth			

ADDRESS INFORMATION

Residential:

Address:	Apt:	City:	State:	Zip:
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Mailing: (if different from Residential address)

Address:	Apt:	City:	State:	Zip:
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Demographics:

Race:	<input type="checkbox"/> White	<input type="checkbox"/> Black/African America	<input type="checkbox"/> Asian	<input type="checkbox"/> Native American/ Alaskan Native	<input type="checkbox"/> Multi-Race
	<input type="checkbox"/> Other _____				
Ethnicity:	Hispanic	Non-Hispanic	Disabled:	<input type="checkbox"/> Y	<input type="checkbox"/> N
<input type="checkbox"/> Any children age 5 or younger <input type="checkbox"/> Anyone 14-24 not in school or working					
<input type="checkbox"/> Received CCAA services in the past 5 years					

BIRTH INFORMATION

City of Birth:	State:	County:
Mother's Name:	Mother's Maiden Name:	Mother's Married Name:
Father's Name:	Date of Birth:	

HEAD OF HOUSEHOLD INFORMATION

Education: Grade 0-8 Grade 9-12 HS Graduate 2-4 Year College Graduate 12 Grade+ Secondary
 Graduate of other post-secondary school GED (Equivalency Diploma) Not applicable

Veteran Info: Veteran Spouse Surviving Spouse Never Served

Health: Medicaid Medicare CHIP State Employment Military Direct Purchase None

Employment:

Full Time Part Time Retired Unemployed Short Term Unemployed Long Term Under 18
 Unemployed Not in labor force

Benefits: SNAP WIC LIHEAP Housing Childcare TANF SSI/SSDI



IMPAIRMENTS

<input type="checkbox"/> Alcoholism	<input type="checkbox"/> Depression	<input type="checkbox"/> Dementia
<input type="checkbox"/> Drug Addiction	<input type="checkbox"/> PTSD	<input type="checkbox"/> Alzheimer's
<input type="checkbox"/> Cancer	<input type="checkbox"/> Schizophrenia	<input type="checkbox"/> Physical Disability
<input type="checkbox"/> Cardiovascular	<input type="checkbox"/> Bi-Polar Disorder	<input type="checkbox"/> Intellectual Disability
<input type="checkbox"/> Other	<input type="checkbox"/> Physician's Name:	<input type="checkbox"/> Physician's Number:

Comment on impairment below:

If you choose Other, please specify: _____

EMERGENCY CONTACT

Emergency Contact #1 Name:		Relationship:	
Phone Number:		Alternate Number:	
Emergency Contact #2 Name:		Relationship:	
Phone Number:		Alternate Number:	

NEXT OF KIN (TO BE NOTIFIED IN EMERGENCY)

Full Name:	Relationship:	
Phone Number:	Email:	
Address:		
City:	State:	ZIP Code:

Household Information

HOUSEHOLD TYPE

<input type="checkbox"/> Alone	<input type="checkbox"/> W/ non-relative	<input type="checkbox"/> Treatment Facility
<input type="checkbox"/> W/ Parents	<input type="checkbox"/> Personal Care	<input type="checkbox"/> Nursing Care Facility
<input type="checkbox"/> W/ Spouse	<input type="checkbox"/> Boarding Home	<input type="checkbox"/> Jail
<input type="checkbox"/> W/ Family	<input type="checkbox"/> Family Care Home	<input type="checkbox"/> Homeless
<input type="checkbox"/> W/ Minor Child	<input type="checkbox"/> Transitional Housing	<input type="checkbox"/> Other



2ND PERSON IN HOUSEHOLD (If more than two people in the home, add to bottom of page)

PERSONAL INFORMATION

FirstName:	LastName:	MI:	Gender: <input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> Other _____
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Phone:	Relationship:	SSN:	DOB:
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Demographics:

Race:	<input type="checkbox"/> White	<input type="checkbox"/> Black/African America	<input type="checkbox"/> Asian	<input type="checkbox"/> Native American/ Alaskan Native	<input type="checkbox"/> Multi-Race
	<input type="checkbox"/> Other _____				
Ethnicity:	Hispanic	Non-Hispanic	Disabled:	<input type="checkbox"/> Y	<input type="checkbox"/> N

Employment:

Full Time Part Time Retired Unemployed Short Term Unemployed Long Term Under 18
 Unemployed Not in labor force

Benefits: SNAP WIC Housing Childcare TANF SSI/SSDI

HOUSING & UTILITY INFORMATION

Housing Type: Private Home Mobile Home Apartment Rented Room

Ownership: Owned Rented Subsidized Non-subsidized

Rent Information

Monthly Rent Amount: \$		Due Date:	
Landlord/Property Manager Name:			
Landlord Phone Number:		Landlord Email:	
Property Address:			

Utilities Information

Electric Company:		Account Number:	
Gas Company:		Account Number:	
Water Company:		Account Number:	
Phone Provider:		Account Number:	
Internet Provider:		Account Number:	
Other:			



Do you currently have a Representative Payee? If yes, answer the questions below

Current Payee Name:	Current Payee Number:
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Explain why you are requesting to change payee services.

Representative Payee Acknowledgement

I understand that by signing and submitting these documents, the Social Security Administration (SSA) may determine it necessary for me to have a representative payee and may appoint Cornerstone Community Action Agency to serve as such.

Note: On page 7 of the Social Security Administration's Guide for Organizational Representative Payees, SSA states, "SSA will never appoint a representative payee solely for a beneficiary's convenience or personal preference."

I Authorize Cornerstone Community Action Agency to submit an application on my behalf to the Social Security Administration to become my Representative Payee.

X

Client Signature

Date

X

CCAA Staff Signature



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Medicare Renewals Information

Section A: Medicare Part A (Hospital Insurance)

Medicare Part A covers inpatient hospital stays, skilled nursing facility care, hospice care, and some home health care.

Current Medicare Part A Information:

Coverage Status:		Policy Number:	
Monthly Premium: \$		Effective Date:	
Insurance Company:		Phone:	
Next Renewal Date:			
<input type="checkbox"/> I authorize CCAA to assist with Medicare Part A information and renewals on my behalf			

Section B: Medicare Part B (Medical Insurance)

Medicare Part B covers doctors' services, outpatient care, medical supplies, and preventive services.

Current Medicare Part B Information:

Coverage Status:		Policy Number:	
Monthly Premium: \$		Effective Date:	
Insurance Company:		Phone:	
Next Renewal Date:			
<input type="checkbox"/> I authorize CCAA to assist with Medicare Part B information and renewals on my behalf			

Section C: Medicare Part C (Medicare Advantage)

Medicare Advantage Plans are an alternative way to receive Medicare benefits through private insurance companies approved by Medicare.

Current Medicare Advantage Information:

Plan Name:		Policy Number:	
Monthly Premium: \$		Effective Date:	
Insurance Company:		Phone:	
Next Renewal Date:			



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<input type="checkbox"/> I authorize CCAA to assist with Medicare Advantage renewals on my behalf

Section D: Dental Insurance

Dental insurance helps cover the costs of routine dental care, preventive services, and dental procedures.

Current Dental Insurance Information:

Plan Name:		Policy Number:	
Monthly Premium: \$		Effective Date:	
Insurance Company:		Phone:	
Next Renewal Date:			
<input type="checkbox"/> I authorize CCAA to assist with dental insurance renewals on my behalf			

Section E: Vision Insurance

Vision insurance helps cover the costs of eye exams, glasses, contact lenses, and other vision care services.

Current Vision Insurance Information:

Plan Name:		Policy Number:	
Monthly Premium: \$		Effective Date:	
Insurance Company:		Phone:	
Next Renewal Date:			
<input type="checkbox"/> I authorize CCAA to assist with vision insurance renewals on my behalf			

Section F: Long-Term Care Insurance

Long-term care insurance helps cover the costs of services for chronic illnesses, disabilities, or conditions requiring extended care.

Current Long-Term Care Insurance Information:

Plan Name:		Policy Number:	
Monthly Premium: \$		Effective Date:	
Insurance Company:		Phone:	
Next Renewal Date:			
<input type="checkbox"/> I authorize CCAA to assist with long-term care insurance renewals on my behalf			



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Section G: Medicare Part D Coverage

Medicare Part D is prescription drug coverage offered through private insurance companies approved by Medicare.

Important Information:

- Annual Enrollment Period (AEP): October 15 - December 7
- Open Enrollment Period (OEP): January 1 - March 31
- Special Enrollment Periods (SEP): Available for qualifying life events

Current Medicare Part D Information:

Plan Name:		Policy Number:	
Monthly Premium: \$		Effective Date:	
Insurance Company:		Phone:	
Next Renewal Date:			
<input type="checkbox"/> I authorize CCAA to assist with Medicare Part D renewals on my behalf			

Section H: Medicare Supplement Insurance (Medigap)

Medigap policies help pay some of the health care costs that Original Medicare doesn't cover, such as copayments, coinsurance, and deductibles.

Current Medigap Information:

Plan Type:		Policy Number:	
Monthly Premium: \$		Effective Date:	
Insurance Company:		Phone:	
Next Renewal Date:			
<input type="checkbox"/> I authorize CCAA to assist with Medigap renewals on my behalf			

Note: CCAA Representative Payee Services will assist with managing premium payments and coordinating renewals. All healthcare decisions remain with the beneficiary or their designated healthcare representative.



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X _____
Client Signature _____ Date _____

X _____
CCAA Staff Signature _____ Date _____



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CLIENT AGREEMENT – Processes and Procedures

Supplemental Security Income (SSI) is a need-based benefit. That means that the amount of money for which you are eligible is based on three things:

1. Your living arrangements
2. Other income/benefits you may receive
3. Your total resources are things you own. For example, bank accounts, stocks, bonds, homes, vehicles, jewelry, etc.

Cornerstone Community Action Agency will not be held responsible for any overpayments due to your failure to notify our office of changes. Notification of changes must be made in writing. This can be done in person by visiting our office, by fax, email or by mailing a signed letter.

IT IS VERY IMPORTANT TO NOTIFY US WITHIN 10 DAYS IF ANY OF ANY CHANGES

RESIDENCE

- You move from your residence
- Someone permanently moves into or out of your residence
- You enter jail or prison (We do not accept phone calls from jail or prison)
- You change your phone number
- You enter or leave a hospital or skilled nursing facility
- You leave the state of Texas

RESOURCES

- The amount of alimony or child support you receive changes
- You inherit or are given money
- You open or close a bank account and if you receive interest on the account
- The amount of any benefit checks you receive directly changes
- You receive money from another source (VA, Railroad Retirement, or pension)
- Your benefits from another source stop
- You start or stop working
- Purchase a burial plot or make burial arrangements
- Purchase a life insurance policy on yourself or someone else
- Buy or sell any car, truck, boat, motorcycle, RV, etc.
- Buy or sell any real estate, including a house, condo or mobile home



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**CONSENT TO OBTAIN OR RELEASE CONFIDENTIAL
INFORMATION**

Name:		Date:	
DOB:			

I hereby give my consent to Cornerstone Community Action Agency Payee Services to obtain and/or exchange information for the purpose of either planning for my well-being and/or assuring my continuing eligibility for Social Security benefits.

I also hereby give my consent to CCAA, Payee Services to obtain and/or exchange information regarding the item(s) below for the purpose of planning/speaking on my behalf for my well-being.

<input type="checkbox"/> Wages/Employment Record	<input type="checkbox"/> Utility Bills
<input type="checkbox"/> Account Ledgers	<input type="checkbox"/> Billing History
<input type="checkbox"/> Current Monthly SSA/SSI	<input type="checkbox"/> Other (Explain Below)
Comment Here:	

I am the individual, to whom the requested information/records apply, or the parent or legal guardian of a minor, or the legal guardian of a legally incompetent adult. I declare 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 CCAA Representative Payee Services is not responsible if a person authorized to obtain information regarding my account does so with false pretenses and CCAA Representative Payee Services is not responsible for any effect on your benefits caused by releasing the requested information.

Printed Name:		Date:	
Signature of Claimant/Legal Guardian:			
CCAA., Staff Member:		Date:	



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What Happens During the Intake Interview at Cornerstone Community Action Agency (CCAA)?

1. Benefit Start and Status

During your intake interview, your Payee Representative will explain when CCAA expects to begin receiving your Social Security benefits.

- If your intake is completed before the Social Security Administration's monthly cutoff date (usually the second Friday of the month), CCAA should receive your benefits for the following month.
- If your benefits are in suspense (temporarily stopped), CCAA will work to reinstate them as quickly as possible.
- If you are a new claimant, CCAA will follow up regularly with the Social Security Administration until your benefits are approved and issued.

2. Your Payee Representative

You will be given your Payee Representative's contact information. This person is your primary point of contact regarding your account and budget. You must notify your Payee Representative promptly of any changes, including:

- Address or living arrangements
- Phone number
- Household or roommate changes

When leaving a voicemail, please include:

- Your first and last name
- A phone number where you can be reached
- A detailed reason for your call

Please leave only one message per day. Multiple messages may delay your response. You may leave a voicemail or email, and Your Payee Representative will respond within 48 hours.

3. Office Hours

The CCAA office lobby in Coleman is open:

- Monday–Thursday: 8:00 a.m. – 5:00 p.m.
- Friday: 8:00 a.m. – 3:00 p.m.

The office is closed on all federal holidays.

4. Budget Setup

A monthly budget is established during your intake appointment.

- If a budget cannot be completed at intake, you must contact your Payee Representative to finalize it before any funds can be released.
- You must provide copies of your lease or rental agreement and any bills you want CCAA to pay on your behalf.

Housing Requirements

- Rent or housing changes must be reported before the 1st of the month. Changes reported on or after the 1st will take effect the following month.
- Housing costs are paid directly to landlords or mortgage companies. Documentation (lease or mortgage statement) is required.
- If you have a roommate, your name must be on the lease, and a copy must be provided.
- Informal living arrangements (living with family or friends) must be supported by a written statement outlining rent amount, due date, and what is included (utilities, meals, phone, etc.).



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What Happens After You Sign Up for CCAA Services?

1. Communication and Appointments

- To contact your Payee Representative, call 325-283-2025.
- Appointments are required for in-person meetings and must be scheduled in advance. Same-day appointments are not available.

2. Budget Compliance

Once your monthly budget is set, you must follow the spending plan for that month. Requests to change the following month's budget must be submitted at least five (5) days before the last business day of the current month.

3. Bill Payment Process

All bills must be sent directly to your Payee Representative. You are responsible for updating your address with vendors, as they will only speak with the account holder.

Vendor bills should be addressed as follows:

Client Name
c/o CCAA Payee Services
114 Needham Street
Coleman, TX 76834

Bill Payment Priority Order

1. Rent
2. Food
3. Utilities
4. Medical
5. Insurance
6. Loans/Credit Cards
(Personal loans to friends or family are not paid by CCAA and must be covered by personal needs funds.)
7. Telephone
8. Cable
9. Spending Money
10. Other approved expenses

Vendor checks are mailed directly to vendors and will not be released to clients.

4. Personal and Additional Funds

Personal and incidental funds are included in your monthly budget.

- If additional funds are available after required expenses, you may request a portion for personal use.
- Personal spending money is issued by check or debit card and mailed to the address on file.
- Requests over \$100 require completion of a *Request for Additional Funds* form.
- Allow at least 24 hours for processing. Requests cannot be approved immediately.
- Payments are processed Tuesdays only.
- Large purchases or additional bills require a revised budget, which may reduce spending money or other expenses.



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5. Holidays and Deposits

CCA observes all federal holidays. If a deposit to your True Link Card is scheduled on a holiday or weekend, it will be issued the business day before.

Observed holidays include:

- New Year's Day
- Martin Luther King, Jr. Day
- Good Friday
- Memorial Day
- Independence Day
- Columbus Day
- Thanksgiving Holiday (Wednesday–Friday)
- Christmas Holiday (day before through day after Christmas)

6. Fees and Reporting

- A monthly fee of \$48, as allowed by the Social Security Administration, will be charged.
- Your Payee Representative completes and submits all required Representative Payee reports.
- Other agencies (Housing, Food Stamps, Medical Assistance) may contact CCAA for income verification. All other information remains the responsibility of the beneficiary.

Important Acknowledgments

By signing up for CCAA services, you acknowledge and understand the following:

1. You must notify your Payee Representative before the last day of the month if you plan to move the following month. Failure to do so may result in rent or mortgage not being paid on time.
2. You are expected to be a responsible member of your community. CCAA may terminate services if there are complaints of property damage, abusive behavior, or chronic intoxication in public. Any remaining funds will be returned.
3. CCAA is committed to responsibly managing your finances to ensure basic needs such as food, shelter, and clothing are met. Services will be terminated if a client is physically or verbally abusive to staff or other clients, or damages CCAA property. Any remaining funds will be returned.

I hereby acknowledge that I understand the Client Agreement and the Cornerstone Community Action Agency procedures and received a copy for my records. I agree to abide by the reporting and procedures requirements to maintain my payee services with CCAA

Client Signature:		Date:	
CCAA Staff Member:		Date:	

**Amalia Martinez,
Representative Payee Specialist
114 Needham
Coleman, Texas 76834
325-283-2025**

**Ginger Wiggins,
Representative Payee
Family Advocate
602 W Water St
Weatherford, Texas 76086
682-253-8418**