



Family Enrollment Application for Representative Payee Services

Please complete the following application to enroll your family member for Representative Payee services through TRUST UNITED in compliance with Social Security Administration (SSA) requirements.

SECTION 1 – BENEFICIARY INFORMATION

Beneficiary Full Name: _____

Date of Birth: _____

Social Security Number: _____

Current Address: _____

Telephone Number: _____

Email Address: _____

Current Living Arrangement:

Primary Language: _____

Marital Status: _____

SECTION 2 – FAMILY / AUTHORIZED REPRESENTATIVE INFORMATION

Family Member / Representative Name:

Relationship to Beneficiary: _____

Telephone Number: _____

Email Address: _____

Address: _____

Guardian / Power of Attorney (If Applicable):

SECTION 3 – SOCIAL SECURITY INFORMATION

Type of Benefits Received: _____

Monthly Benefit Amount: _____

Current Representative Payee (If Applicable):

SSA Office Location: _____

Date Benefits Started: _____

SECTION 4 – HOUSING AND FACILITY INFORMATION

Name of Facility / Residence:

Facility Type (ALF, Group Home, Nursing Home, etc.):

Monthly Rent / Housing Expense:

Facility Contact Person: _____

Facility Telephone Number: _____

SECTION 5 – MONTHLY EXPENSES AND FINANCIAL OBLIGATIONS

Rent / Housing: _____

Utilities: _____

Food: _____

Transportation: _____

Medications: _____

Medical Expenses: _____

Personal Spending Allowance:

Other Expenses: _____

SECTION 6 – REQUIRED DOCUMENTATION CHECKLIST

Copy of Social Security Card

Government-Issued Identification

Social Security Award Letter

Lease Agreement or Housing Verification

Guardianship / POA Documents (If Applicable)

Medical or Mental Health Documentation (If Applicable)

Banking Information (If Applicable)

Emergency Contact Information

Completed TRUST UNITED Intake Forms

SECTION 7 – EMERGENCY CONTACT INFORMATION

Primary Emergency Contact:

Relationship: _____

Telephone Number: _____

Secondary Emergency Contact:

Preferred Hospital: _____

Known Allergies / Medical Alerts:

SECTION 8 – AUTHORIZATION AND CONSENT

I hereby authorize TRUST UNITED to communicate with the Social Security Administration, healthcare providers, landlords, facilities, banks, and related service providers as necessary for Representative Payee services.

I certify that the information provided within this application is accurate to the best of my knowledge.

SIGNATURES

Family Member, Print Name: _____

Authorized Representative Signature: _____

Date: _____

Beneficiary Name: _____

Beneficiary Signature: _____ **Date:** _____

TRUST UNITED Representative: _____

Date: _____