RESOURCE OVERSIGHT & GUIDANCE SERVICES, INC.

A 501 (c) (3) Non-Profit Organization

ORGANIZATIONAL REPRESENTATIVE PAYEE APPLICATION

ROG SERVICES

Name:	SS#:	DOB:	
Address:	City:	State:	Zip:

Home Phone:	Cell Phone:
Emergency Contact Name:	Emergency Contact Phone:
Email Address:	Father's full name:
City and State of Birth:	Mother's maiden name:
Marital Status: S◯ M◯ D◯ W◯	Employment Status: E◯ U◯ R◯ D◯
Living arrangement: Alone☐ Relative☐ B&C☐ Nursing home☐ public inst☐ ILF☐ R&B☐ Other☐	
How long at current address:	Any expected changes:

Landlord Information

Name:	Phone #:		
Address:	City:	State:	Zip:
Change of Payee Requested: Y◯ N◯	If Yes, By Whom:		
Previous Payee Name:	Previous Payee Phone:		
Case Worker Name:	Case Worker Phone:		
Case Worker Agency Name:			
Sources of Income: SSDI☐ SSI☐ VA☐ Other☐ (Explain):			
Amount of Monthly Income: $			

Monthly Expenses

Rent:$	Transportation:$
Telephone:$	Personal Funds:$
Electric/Gas:$	Other:_____$
Cable:$	Other:_____$
Internet:$	Other:_____$
Insurance:$	Other:_____$
Cell Phone:$	Other:_____$
Court Appointed Legal Guardian: Y◯ N◯	Date of appointment:
Name of Guardian:	Relationship:
Address:	Phone #:
Reason rep payee is necessary:	
Additional information:	
Please attach a copy of state ID or driver's license with application	
Signature:	Date:

P.O. Box 7394 Laguna Niguel CA 92607 ♦ 800-764-7166 ♦ fax: 800-609-3166 ♦ rogservices@rogservices.com

Resource Oversight & Guidance Services, Inc

P.O Box 7394
Laguna Niguel, CA 92607
phone: 800-764-7166; fax: 800-609-3166
www.rogservices.org

Consent to Release Information

To: **Resource Oversight & Guidance Services, Inc.**

Name:_____

SSN:_____

Date of Birth:_____

I hereby give my consent to **Resource Oversight & Guidance Services, Inc.** 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 **Resource Oversight & Guidance Services, Inc.** to obtain and/or exchange information regarding the item(s) below for the purpose of planning for my well-being:
Social Security Number, Account Statement, Current Monthly SSA/SSI, Bank Account, Burial Trust, Medi-Cal, Wages/Employment Record, Social History, Utility Bills, O.H.S. Plan / Appointments, Address/Living Arrangement, or Other (explain below)

_____

I am the individual, to whom the requested information/records applies, 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 of 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 **Resource Oversight & Guidance Services, Inc.** is not responsible if a person authorized to obtain information regarding my account does so with false pretenses and **Resource Oversight & Guidance Services, Inc.** is not responsible for any effect to your benefits caused by releasing the requested information.

_____ _____
Print Name Date

_____ _____
Signature of Claimant or Legal Guardian Relationship (if not claimant)

_____ _____
ROG Services, Inc. Staff Member Date

Resource Oversight & Guidance Services, Inc.

A non-profit organization
P.O. Box 7394
Laguna Niguel, CA 92607

REPRESENTATIVE PAYEE/PAYOR CONTRACT

I, _____have discussed my needs with Resource Oversight and Guidance Services, Inc. and I agree to have Resource Oversight and Guidance Services, Inc. serve as my organizational representative payee for my Social Security benefits. I understand there is a monthly fee for service set annually by the Social Security Administration (SSA).

I will:

- Be clean and sober when I conduct business by phone or in person.
- Treat staff with courtesy and respect.
- Come to conduct business by appointment only.
- Receive my personal spending funds from the facility where I reside or via a check or prepaid debit card, whichever method works best for everyone involved.
- Allow Resource Oversight and Guidance Services, Inc to deposit any checks payable to me to be deposited into a trust account on my behalf and utilized in my best interest.
- Receive an account ledger any time upon request.
- Comply with these rules and understand that if I fail to comply, Resource Oversight and Guidance Services, Inc. may request SSA to remove the agency as my representative payee.

Resource Oversight and Guidance Services, Inc. will:

- Treat me with courtesy and respect.
- Be available Monday through Friday from 9 and 5 p.m. by phone or to meet with me by appointment only.
- Use funds received on my behalf to first meet my current needs for food, housing, clothing, medical care and personal comfort items.
- Report to SSA any events that may affect your eligibility for payments or payment amount.
- Account to SSA on how your money has been spent/saved and complete all required reports.
- Save any unspent funds, if any, for future needs, and
- Return to SSA any funds saved (in the event of a change in payee) or any funds that were sent for your benefit but to which you are not entitled.

Beneficiary Signature_____ Date_____

Representative Name_____Signature_____Date_____

Advance Notification of Representative Payment

Name of Wage Earner, Self-Employed Person or SSI Claimant	Social Security Number – –
Name of Beneficiary (if other than above	Relationship to Wage Earner, Self-Employed Person or SSI Claimant

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 interests.

Choice of Representative Payee

SSA has selected Resource Oversight & Guidance Services, Inc, to be my representative payee.

My Right to Appeal

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

1. Signature of Witness	2. Signature of Witness
Address (Number and Street, City, State and ZIP Code)	Address (Number and Street, City, State and ZIP Code)

Form **SSA-4164** (9-1994) ef (5-2005)
Destroy Prior Editions

Whose Records to be Disclosed	
NAME *(First, Middle, Last, Suffix)*	
SSN	Birthday *(MM/DD/YYYY)*

AUTHORIZATION TO DISCLOSE INFORMATION TO THE SOCIAL SECURITY ADMINISTRATION (SSA)

**** PLEASE READ THE ENTIRE FORM, BOTH PAGES, BEFORE SIGNING BELOW ****

I voluntarily authorize and request disclosure (including paper, oral, and electronic interchange):

OF WHAT ***All my medical records: also education records and other information related to my ability to perform tasks. This includes Specific permission to release:***

1. **All records and other information regarding my treatment, hospitalization, and outpatient care for my impairment(s) including, and not limited to:**
   - Psychological, psychiatric or other mental impairment(s) (excludes "psychotherapy notes" as defined in 45 CFR 164.501)
   - Drug abuse, alcoholism, or other substance abuse
   - Sickle cell anemia
   - Records which may indicate the presence of a communicable or noncommunicable disease; and tests for or records of HIV/AIDS
   - Gene-related impairments (including genetic test results)
2. **Information about how my impairment(s) affects my ability to complete tasks and activities of daily living, and affects my ability to work.**
3. **Copies of educational tests or evaluations, including Individualized Educational Programs, triennial assessments, psychological and speech evaluations, and any other records that can help evaluate function; also teachers' observations and evaluations.**
4. **Information created within 12 months after the date this authorization is signed, as well as past information.**

FROM WHOM

- **All medical sources** (hospitals, clinics, labs, physicians, psychologists, etc.) including mental health, correctional, addiction treatment, and VA health care facilities
- All educational sources (schools, teachers, records administrators, counselors, etc.)
- Social workers/rehabilitation counselors
- Consulting examiners used by SSA
- Employers, insurance companies, workers' compensation programs
- Others who may know about my condition (family, neighbors, friends, public officials)

THIS BOX TO BE COMPLETED BY SSA/DDS (as needed). Additional information to identify the subject (e.g., other names used), the specific source, or the material to be disclosed:

TO WHOM **The Social Security Administration and to the State agency authorized to process my case (**usually called "disability determination services"), **including contract copy services, and doctors or other professionals consulted during the process.** [Also, for international claims, to the U.S. Department of State Foreign Service Post.]

PURPOSE Determining my **eligibility for benefits**, including looking at the combined effect of any impairments that by themselves would not meet SSA's definition of disability; and whether I can manage such benefits.

☐ Determining whether I am **capable of managing benefits ONLY** (check only if this applies)

EXPIRES WHEN This authorization is good for 12 months from the date signed (below my signature).

- I authorize the use of a copy (including electronic copy) of this form for the disclosure of the information described above.
- I understand that there are some circumstances in which this information may be redisclosed to other parties (see page 2 for details).
- I may write to SSA and my sources to revoke this authorization at any time (see page 2 for details).
- SSA will give me a copy of this form if I ask; I may ask the source to allow me to inspect or get a copy of material to be disclosed.
- **I have read both pages of this form and agree to the disclosures above from the types of sources listed.**

PLEASE SIGN USING BLUE OR BLACK INK ONLY **INDIVIDUAL authorizing disclosure Signature**	**IF not signed by subject of disclosure, specify basis for authority to sign** ☐ Parent of minor ☐ Guardian ☐ Other personal representative (explain)
	(Parent/guardian/personal representative sign here if two signatures required by State law)

Date Signed	Street Address		
Phone Number (with area code)	City	State	ZIP

WITNESS *I know the person signing this form or am satisfied of this person's identity:*

Signature	**IF** needed, second witness sign here (e.g., if signed with "X" above)
Phone Number (or Address)	Phone Number (or Address)

This general and special authorization to disclose was developed to comply with the provisions regarding disclosure of medical, educational, and other information under P.L. 104-191 ("HIPAA"); 45 CFR parts 160 and 164; 42 U.S. Code section 290dd-2; 42 CFR part 2; 38 U.S. Code section 7332; 38 CFR 1.475; 20 U.S. Code section 1232g ("FERPA"); 34 CFR parts 99 and 300; and State law.

Explanation of Form SSA-827, "Authorization to Disclose Information to the Social Security Administration (SSA)"

We need your written authorization to help get the information required to process your claim, and to determine your capability of managing benefits. Laws and regulations require that sources of personal information have a signed authorization before releasing it to us. Also, laws require specific authorization for the release of information about certain conditions and from educational sources.

You can provide this authorization by signing a form SSA-827. Federal law permits sources with information about you to release that information if you sign a single authorization to release all your information from all your possible sources. We will make copies of it for each source. A covered entity (that is, a source of medical information about you) may not condition treatment, payment, enrollment, or eligibility for benefits on whether you sign this authorization form. A few States, and some individual sources of information, require that the authorization specifically name the source that you authorize to release personal information. In those cases, we may ask you to sign one authorization for each source and we may contact you again if we need you to sign more authorizations.

You have the right to revoke this authorization at any time, except to the extent a source of information has already relied on it to take an action. To revoke, send a written statement to any Social Security Office. If you do, also send a copy directly to any of your sources that you no longer wish to disclose information about you; SSA can tell you if we identified any sources you didn't tell us about. SSA may use information disclosed prior to revocation to decide your claim.

It is SSA's policy to provide service to people with limited English proficiency in their native language or preferred mode of communication consistent with Executive Order 13166 (August 11, 2000) and the Individuals with Disabilities Education Act. SSA makes every reasonable effort to ensure that the information in the SSA-827 is provided to you in your native or preferred language.

Privacy Act Statement
Collection and Use of Personal Information

Sections 205(a), 223(d), and 1631(d) of the Social Security Act, as amended, allow us to collect this information. Furnishing us this information is voluntary. However, failing to provide all or part of the information may prevent us from making an accurate and timely decision on your claim that could result in a denial or loss of benefits.

We will use the information you provide to determine your eligibility or continuing eligibility for benefits, and your ability to manage any benefits that you currently receive.

We may also share your information for the following purposes, called routine uses:

1. To State audit agencies for auditing State supplementation payments and Medicaid eligibility considerations;
2. To third party contacts where necessary to establish or verify information provided by representative payees or payee applicants; and
3. To Federal, State or local agencies for administering cash or non-cash income maintenance or health maintenance programs.

In addition, we may share this information in accordance with the Privacy Act and other Federal laws. For example, where authorized, we may use and disclose this information in computer matching programs, in which our records are compared with other records to establish or verify a person's eligibility for Federal benefit programs and for repayment of incorrect or delinquent debts under these programs.

A list of additional routine uses is available in our Privacy Act System of Records Notices (SORNs) 60-0089, entitled Claims Folders Systems; 60-0090, entitled Master Beneficiary Record; 60-0320, entitled Electronic Disability; and 60-0103, entitled Supplemental Security Income Record and Special Veterans Benefits. Additional information and a full listing of all our SORNs are available on our website at www.socialsecurity.gov/foia/bluebook.

Paperwork Reduction Act Statement

This information collection meets the requirements of 44 U.S.C. § 3507, as amended by section 2 of the Paperwork Reduction Act of 1995. You do not need to answer these questions unless we display a valid Office of Management and Budget control number. We estimate that it will take about 10 minutes to read the instructions, gather the facts, and answer the questions. **SEND OR BRING THE COMPLETED FORM TO YOUR LOCAL SOCIAL SECURITY OFFICE. You can find your local Social Security office through SSA's website at www.socialsecurity.gov. Offices are also listed under U. S. Government agencies in your telephone directory or you may call Social Security at 1-800-772-1213 (TTY 1-800-325-0778).** *You may send comments on our time estimate above to: SSA, 6401 Security Blvd, Baltimore, MD 21235-6401.* ***Send only comments relating to our time estimate to this address, not the completed form.***

Medical Source Opinion of Patient's Capability to Manage Benefits

	In replying, use this address: SOCIAL SECURITY ADMINISTRATION
	TELEPHONE NUMBER (Including Area Code)
	DATE
	SSA CONTACT

IDENTIFYING INFORMATION (SSA Only)
If different from patient

NAME OF WAGE EARNER OR SELF-EMPLOYED PERSON	SOCIAL SECURITY NUMBER

PATIENT'S NAME

PATIENT'S SOCIAL SECURITY NUMBER	PATIENT'S DATE OF BIRTH

PATIENT'S ADDRESS (Number and Street, City, State, and ZIP Code)

YOUR HELP IS NEEDED

The patient shown above has filed for or is receiving Social Security or Supplemental Security Income benefits. We need you to complete the back of this form and return it to us in the enclosed envelope to help us decide if we should pay this person directly or if he or she needs a representative payee to manage the Social Security Administration (SSA) benefits on his or her behalf.

Please Note: This determination affects how benefits are paid and has no bearing on disability determinations. Unfortunately, SSA cannot compensate you for the time it takes to provide this information. Thank you for your help.

WHAT IS A REPRESENTATIVE PAYEE

A representative payee is someone who manages the patient's SSA benefits to make sure the patient's basic needs are met. The payee has a strong and continuing interest in the patient's well-being and is usually a family member or close friend.

WHO NEEDS A REPRESENTATIVE PAYEE

Some individuals age 18 and older who have mental or physical impairments are not capable of managing their SSA benefits or directing others to manage them to meet their basic needs, so we select a representative payee to receive their benefits on their behalf. Examples of impairments that may cause incapability are dementia, brain damage or chronic schizophrenia. However, a person's need for some assistance with financial tasks such as bill paying, etc., does not necessarily mean he or she cannot make decisions concerning basic needs and is incapable of managing his or her own benefits. If the individual is able to direct the management of his or her own benefits, then we will consider the individual capable.

PLEASE COMPLETE THE INFORMATION ON THE REVERSE OF THIS FORM

PATIENT'S NAME

PATIENT'S SOCIAL SECURITY NUMBER	PATIENT'S DATE OF BIRTH

PATIENT'S ADDRESS (Number and Street, City, State, and ZIP Code)

1. Date you first saw the patient

2. Date you last saw the patient

3. How many times have you seen this patient?

4. Are you able to assess the patient's ability to manage or direct the management of funds? ☐ Yes ☐ No

   If no, please skip the remaining questions and sign and date the form.

5. What is the basis for your assessment (e.g. observation, medical records, diagnostic tests, patient's self-report, family member's report)?

Note: Please keep in mind in responding to the following questions that the actual performance of the patient, when known, is usually the best indicator of the patient's abilities.

6. Does the patient:

- Have a general understanding of his or her finances (i.e., income, assets, expenses)? ☐ Yes ☐ No ☐ Unknown
- Have sufficient ability to handle a checking/savings account? ☐ Yes ☐ No ☐ Unknown
- Have sufficient ability to pay bills in a timely manner? ☐ Yes ☐ No ☐ Unknown

7. Can the patient successfully manage or direct the management of funds to meet basic needs (e.g. food, clothing, shelter)?

☐ Yes
If "Yes," please provide a brief summary of the findings that led to this conclusion, and complete question 8. Please also sign and date the form.

☐ No
If "No," please provide a brief summary of the findings that led to this conclusion, and complete question 8. Please also sign and date the form.

☐ Unsure
"Unsure," please explain and sign and date the form.

8. Do you expect the patient to be able to manage or direct the management of his or her benefits in the future (e.g. the patient is temporarily unconscious)?

☐ Yes ☐ No

Please explain your answer.

NAME OF MEDICAL SOURCE (Please print.)	TITLE
ADDRESS (Number and Street, City, State, and ZIP Code)	TELEPHONE NUMBER (*Include Area Code)*

I declare under penalty of perjury 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 anyone who knowingly gives a false statement about a material fact in this information, or causes someone else to do so, commits a crime and may be subject to a fine or imprisonment.

SIGNATURE OF MEDICAL SOURCE	DATE

Privacy Act Statement
Collection and Use of Personal Information

Sections 205, 807, and 1631(a) of the Social Security Act, as amended, allow us to collect this information. Furnishing us this information is voluntary. However, failing to provide all or part of the information may prevent us from making a determination regarding the beneficiary's capability or inability to handle his or her own benefits.

We will use the information to determine the beneficiary's need for a representative payee. We may also share your information for the following purposes, called routine uses:

- To Federal, State, or local agencies for administering cash or non-cash income maintenance or health maintenance programs; and

- To contractors and other Federal agencies, as necessary, for the purpose of assisting the Social Security Administration in the efficient administration of its programs.

In addition, we may share this information in accordance with the Privacy Act and other Federal laws. For example, where authorized, we may use and disclose this information in computer matching programs, in which our records are compared with other records to establish or verify a person's eligibility for Federal benefit programs and for repayment of incorrect or delinquent debts under these programs.

A list of additional routine uses is available in our Privacy Act System of Records Notices (SORN) 60-0089, entitled Claims Folders Systems, as published in the Federal Register (FR) on April 1, 2003, at 68 FR 15784, and 60-0222, entitled Master Representative Payee File, as published in the FR on April 22, 2013, at 78 FR 23811. Additional information, and a full listing of all our SORNs, is available on our website at www.ssa.gov/privacy.

Paperwork Reduction Act Statement - This information collection meets the requirements of 44 U.S.C. § 3507, as amended by section 2 of the Paperwork Reduction Act of 1995. You do not need to answer these questions unless we display a valid Office of Management and Budget control number. We estimate that it will take about 20 minutes to read the instructions, gather the facts, and answer the questions. **SEND OR BRING THE COMPLETED FORM TO YOUR LOCAL SOCIAL SECURITY OFFICE. You can find your local Social Security office through SSA's website at www.socialsecurity.gov. Offices are also listed under U.S. Government agencies in your telephone directory or you may call Social Security at 1-800-772-1213 (TTY 1-800-325-0778).** *You may send comments on our time estimate above to*: *SSA*, *6401 Security Blvd, Baltimore, MD 21235-6401.* ***Send only comments relating to our time estimate to this address, not the completed form.***

APPLICATION FOR CALIFORNIA RESTAURANT MEALS ALLOWANCE

Applicant/ Recipient's Name	SSN

I am applying for the Restaurant Meals Allowance and understand that to be eligible the following requirements must be met

- I do not receive meals as part of my living arrangement, **and**
- Beginning _____, one of the following conditions exists:

☐ I do not have access to a working refrigerator or icebox

☐ My cooking facilities are inadequate; I do not have access to a working oven (regular or microwave) plus at least one temperature controlled heating unit, or at least two temperature controlled heating units (but no functioning stove)

☐ My cooking or food storage facilities are temporarily not working and are not expected to be working until _____.

I certify the above to be true and know that providing false statements or misrepresentation of the fact is punishable under Federal and /or State law.

I understand that the California Restaurant Meals Allowance ends with the month in which I receive meals as part of my living arrangement or I have access to adequate cooking and food storage facilities.

I agree to immediately notify Social Security if there is any change in my living arrangement as described above.

Applicant Signature	*SSN*	*Date*

SSA Decision:

* Approved effective: _____

* Denied, Notice of Planned Action Provided (redetermination only)

Claims Representative	*Signature*	*Date*	*DO*

Date: _____

To: Social Security Administration

From: _____ Social Security #: _____

Re: Request to change representative payees

Dear Social Security,

I hereby notify Social Security that I am requesting to change from my existing representative payee,

_____,
to a new organizational representative payee, Resource Oversight & Guidance Services, Inc., a nonprofit organization, effective immediately.

I am making this change request because:

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Signed,

_____

Date:

To: Social Security Administration

From:

Re: Request to relinquish representative payee duties

I _____, am currently serving as the representative payee for

_____, social security #:_____.

I am formally requesting that Resource Oversight & Guidance Services, Inc. assume the responsibilities of representative payee for _____. I am no longer am able to continue in this role due to reasons outlined below. I believe that Resource Oversight & Guidance Services is well-qualified and best suited to manage this responsibility moving forward.

Signed:

Explanation:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

NOTICE OF PRIVACY PRACTICES

Resource Oversight & Guidance Services, Inc. (ROG Services, Inc.)

Effective Date: January 1, 2026

THIS NOTICE DESCRIBES HOW HEALTH AND PERSONAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Our Responsibilities

ROG Services is required by law to maintain the privacy of your Protected Health Information (PHI) and Personally Identifiable Information (PII). We must provide you with this Notice of our legal duties and privacy practices and follow the terms of this Notice.

Uses and Disclosures of Information

ROG Services may use or disclose your information for purposes of treatment coordination, payment activities, and health care operations as permitted by law. We may also disclose information when required by law or to prevent a serious threat to health or safety.

Your Rights

You have the right to request restrictions, request confidential communications, inspect and obtain a copy of your records, request amendments, and receive an accounting of disclosures as provided by law.

Complaints

If you believe your privacy rights have been violated, you may file a complaint with ROG Services or with the U.S. Department of Health and Human Services. You will not be retaliated against for filing a complaint.

Contact Information

Privacy Officer: Dean Reyburn, President
Phone: (800) 764-7166 x105
Email: deanreyburn@rogservices.com

Changes to this Notice

ROG Services reserves the right to change this Notice and make the new Notice effective for all information we maintain.