Minka, Inc.

P.O. Box 412
ELK RIVER, MN 55330
PH: (763) 274 -0708 FAX: (763) 441-4828

Thank you for contacting Minka, Inc., for Representative Payee services.

Please fill in all blanks on the enclosed application. If living out in the community **please include your lease with Landlords information.**

Lifetime Release for Social Security:

1. This form can **only** be signed by the client. ***(Per Social Security, the Guardian or any other representative may NOT sign this form).***

Release of information is needed for the county, housing etc:

1. County of financial responsibility to coordinate benefits.
2. Rent or housing to ensure correct payment.
3. Anyone you would like us to speak to about your financials.
4. Should you need more Releases feel free to copy.

We will not disclose any information without a written release or acknowledge that we know of you. You may revoked a release at any time, simply by giving us a call.

In order for us to coordinate benefits with your county worker we need you to sign the authorized representative form.

Personal Needs funds:

Minka, Inc. will assign you a "Select" Paycheck MasterCard that is dark blue and silver. This is not a credit card but a debit card. Funds will be loaded onto the card, and it can be used just like a regular credit card. **Please swipe as credit never debit card.** We recommend this option because it **is the safest and most reliable way to receive your personal needs**. By using the debit card your funds will be loaded on a schedule. No more waiting for a check to come in the mail. Also, there is no worry about a check being lost or stolen.

Once the application is received we can start the approval process with Social Security. Social Security guidelines allows a $41.00 monthly fee for Representative Payee services. In some cases the county will reimburse you this fee.

If you have any question please contact our office. **Everyone on our staff** will be happy to help you complete the application, and answer any question you may have.

Respectfully,
Christine Pastor
President

MINKA, INC. PO Box 412 Elk River MN 55330 PH: (763) 274-0708 Fax: (763) 441-4828	**New Reguirement by SSA:** **Please include a letter from LSW, and/or a Physician statement in regards to the need for a professional Payee. Also, needed is a State ID, and/or SSN Card , Birth Certificate.**	
Name: Alias if any:	SSN:	D.O.B.:
Clients Physical Address: Move in date: ***** Please include Lease*****	City:	State and Zipcode:
Previous Address:	Date Move in:	Date Move out:
Case/Maxis #:	PMI#:	
Medicare #:	A B D (please circle one or more) (A) Date: (B) Date:	
Phone: Cell:	Emergency Contact information: Relationship:	
Diagnosis:		
Mothers Maiden Name, address and phone number:	Fathers Name, address and phone number:	
Guardian or Conservator Name, address and phone #:	Date of Appointment: *******Please include Copy of Court order*******	
County Services Contacts		
County Case Manager:	Phone/Fax:	County:
County Financial Worker:	Phone/Fax:	County:
ILS / Arms Contact		
Name & Address:	Phone/Fax:	County:
Physician Information		
Primary Physician:	Phone/Fax:	Clinic:
Psychiatrist/Psychologist	Phone/Fax:	Clinic:

Vital Information needed to help complete forms for County and Social Security

Do you Live on a Reservation: Yes No	**If yes please provide name of Reservation:**
Are you a Military Veteran: Yes No	**Branch of Service and date served:**
Are you Blind: Yes No	**Most recently moved to Minnesota (mm/dd/yy):**
Marital Status: Date: Divorce: Date:	**If Maried - Spouses Name, Address and Phone#:** SSN: DOB:

Do you have Children under the age of 18. Please provide below:

Name: DOB: SSN:	Name: DOB: SSN:
Are you Pregnant: Yes No Due Date:	Name: DOB: SSN:

Do you own a Vehicle: Make: Model: Year:	**Do you own any Stocks and/or Bonds:**
Life Insurance: **Name of Insurance:**	**Burial Policy:** **Name of Insureance:**

Do you have a Checking / Savings Account: Yes No
Name of Bank :
Checking Account Number:
Savings Account Number:

Cash on Hand: Yes No Amount: $

What is your preferred spoken language:	**What is your preferred written language:**
U.S. Citizen or U.S. National? Yes No	**Ethnicity (optional)** Hispanic? Yes No
Race (optional)	**Last School Grade Completed:**

Do you live alone if not how many people live with you: ***Please Provide Names & Birthdates****

Has anyone in the household received any Cash, Medical Assistance, Snap Support:
What received:____________________________
What County:____________________________
When:________________________________

Income Amount and Source:

RSDI:	SSI:	VA:	RRB:	MSA:	Snap:	MFIB:	Pension:	Annuity:

Employer Name, Address and Phone:	Hourly Wage:
Hire Date:	

Monthly Expenses

Debtor Information	Name and Address	Amount
Rep Payee Fee 2015	Minka Inc PO Box 412 Elk River MN 55330 Ph: (763) 274-0708 Fax: (763) 441-4828	$41.00
Please circle one: **Adult Foster Care** **Assisted Living** **Independent Living** **Board & Lodge** **Nursing Home**	**Landlords Name, Address & Phone:**	
Child Support		
Student Loan		
Electric		
Cable		
Cell Phone Prepaid or Plan		
Health Insurance: **MA-EPD** **Other**		
Pharmacy		
Medical Bills **Spend down**		
Insurance **Auto:** **Renters:** **Life:**		
Credit Card/Other		

SOCIAL SECURITY ADMINISTRATION

AUTHORIZATION FOR THE SOCIAL SECURITY ADMINISTRATION TO OBTAIN PERSONAL INFORMATION

Authorizing Person (Person about whom information is being requested)	Social Security Number
Claimant/Beneficiary (If other than authorizing person)	Claimant's/Beneficiary's Social Security Number

I authorize any public or private custodian of records to disclose to the Social Security Administration any records or information about me. In the case of a minor or incapable person, I, as guardian or representative, authorize the same disclosure of records about the person I represent.

Authorizing Person's Signature		Date
Mailing Address	City and State	ZIP Code

Your authorization does not ordinarily have to be witnessed. However, if you have signed by mark (X), two witnesses to the signing who know you must sign below giving their full addresses.

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

Privacy Act Statement
Collection and Use of Personal Information

Sections 205(a) and 1631(e) of the Social Security Act, as amended, authorize us to collect this information. We will use the information you provide on this form to obtain information about you from any public or private custodian regarding your eligibility for Social Security benefits.

You do not have to provide us this information. Your responses are voluntary. However, failure to provide all or part of the information could prevent us from making an accurate and timely decision regarding your Social Security benefits.

We rarely use this information you supply for any purpose other than for reviewing your claim for Social Security benefits. However, we may use it for the administration and integrity of Social Security programs. We may also disclose information to another person or to another agency in accordance with approved routine uses, which include but are not limited to the following: 1. To enable a third party or an agency to assist Social Security in establishing rights to Social Security benefits and/or coverage; 2. To comply with Federal laws requiring the release of information from Social Security records (e.g., to the Government Accountability Office and Department of Veterans' Affairs); 3. To make determinations for eligibility in similar health and income maintenance programs at the Federal, State, and local level; and, 4. To facilitate statistical research, audit, or investigative activities necessary to assure the integrity and improvement of Social Security programs.

We may also use the information you provide in computer matching programs. Matching programs compare our records with records kept by other Federal, State, or local government agencies. Information from these matching programs can be used to establish or verify a person's eligibility for Federally-funded or administered benefit programs and for repayment of payments or delinquent debts under these programs.

A complete list of routine uses for this information are available in our System of Records Notices entitled, Claims Folders Systems (60-0089) and the Master Beneficiary Record (60-0090). These notices, additional information regarding this form, routine uses of information, and our programs and systems are available on-line at www.socialsecurity.gov or at your local Social Security office.

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Minnesota Health Care Programs

Giving Permission for Someone to Act on My Behalf

Date: ____________________

To: ____

____

____

Case number: ____________________

Case name: ____________________

Worker name: ____________________

Worker phone number: ____________________

Fax number: ____________________

Agency name: ____________________

Agency address: ____________________

____

Why am I getting this letter?

You asked to give permission to another person to act on your behalf. This person will have the same responsibilities and rights as you regarding your Minnesota Health Care Programs eligibility. He or she will receive forms, notices and premium notices on your behalf.

What do I need to do?

Read the information below. Enter the name of the person you want to act on your behalf. Both you and this person must sign and date the form. Return this letter to the address listed above.

I want to give permission for someone to act on my behalf.

I understand this person:

- Must be at least 18 years old and know my circumstances in order to provide necessary information about me.
- May be a friend, relative, someone appointed by the court or another person I give permission to.
- Can help me fill out forms, give information about me and report changes that may affect my Minnesota Health Care Programs coverage.
- Will act for me until I no longer want him or her to. I will tell my worker when I want this to end.

I give permission to ____ to act for me.
(PRINT THE FIRST AND LAST NAME OF THE PERSON ACTING ON YOUR BEHALF)

YOUR NAME (print)	YOUR SIGNATURE		DATE
SIGNATURE OF PERSON ACTING ON YOUR BEHALF	DATE		PHONE NUMBER
HIS/HER STREET ADDRESS	CITY	STATE	ZIP CODE

Questions?

Call your worker at the number listed above if you have questions.

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TEL: (763) 274-0708 FAX: (763) 441-4828

This Authorization allows Minka, Inc:
☐ ***give information to others***
and/or
☐ ***get information from others***

AUTHORIZATION FOR RELEASE OF INFORMATION - MINKA, INCORPORATED

______________________________ Name of Client

______________________________ Date of Birth

I authorize Minka, Inc. Po Box 412, Elk River, MN 55330 to:

☐ give information to: ☐ get information from:

Name of Agency or Individual______________________________
Address:______________________________
Phone:______________________________ Fax:______________________________
Contact Person:______________________________

This Authorization applies to pertinent information from my financial/billing record that are maintained while I am a client of Minka, Inc.

This information is necessary for the purpose of:

__________ Obtain GRH / Spenddown obligations
__________ Lease for Housing / Rental obligation
__________ Utility billing
__________ Work history / payroll for SSA / County reporting
__________ Medical information pertinent for SSA reporting
__________ Child support payments
__________ Student Loan payments
__________ Spousal Maintenance
__________ Other (Specify)______________________________

I understand that I have the right to refuse to sign this consent.
This release is valid for the duration while I am a client of Minka, Inc.
I may revoke this authorization at any time. This will not affect any actions Minka, Inc., took in reliance on this authorization before I revoke it.
Once information is released to a third party, according to this authorization, Minka, Inc., cannot prevent its re-disclosure.

____
Signature of Client or Client Representative/Guardian

____
Date

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Signature of Client or Client Representative/Guardian **Date**

Minka, Inc.

P.O. Box 412
ELK RIVER, MN 55330
PH: (763) 274 -0708 FAX: (763) 441-4828
chris@minkinc.com **or** theresa@minkainc.com **or** daen@minkainc.com

Information and Rules: ****Please read carefully and Initial****

As a new member of our services, here is some information that will be useful to you. Please initial each sections below, and retain a copy for your records.

Our office hours are:

Monday - Thursday phone hours are 9am - 3pm. **Friday is a paper day and we do not answer the phone.** However you may leave a message that will be returned as soon as we are available. **Minka, Inc. is closed on weekends and all National Holidays.**

Phone number **763-274-0708**. Fax number **763-441-4828.**

Mailing address: **PO Box 412**
Elk River MN 55330

________When calling our office: You may speak to **any of the Associates**, and they will be able to help you. If you receive the voice mail during business hours, **PLEASE LEAVE ONLY ONE MESSAGE.** We are on the other phone line assisting another client and unable to answer your call at that time. When leaving a message, include **your name, phone number**, and the reason for your call. We check our messages regularly and will return your call as soon as possible. All calls may be recorded. Messages left with foul or abusive language will not be returned. Foul or abusive language on live phone call will be terminated.

_________If you would like us to have your email address, please write it below.

EMAIL ADDRESS IS ____

_________Now that you have changed or requested a Representative Payee, it is very important that you contact us within the next couple of weeks. When you call please have all of your bills and expenses handy. At that time we will be able to determine your budget, providing we have all the correct figures. The Associate that you will talk to will be able to give you an idea of your personal needs amount. This will depends on your spending habits and budget.

_________ You will receive a new **Select debit card**. Your personal needs will be loaded onto this card. **You will need to activate this card. Due to the Patriot Act we are not able to look up information on your card**. PLEASE CALL OUR OFFICE IMMEDIATELY AND LET US KNOW YOU HAVE RECEIVED YOUR CARD.

Once we hear from you, and funds are available we will be able to load money onto your card. **If you need additional funds, besides your scheduled personal needs, you will need to inform us 5 business days prior to the date of need. You can check the balance on your card at any time by calling the (877) 380-0978 phone number on the back of your card keep this phone number written down in a separate place in case you lose your card.** This can take 5 to 10 business days to receive the replacement card. **Keep your card safe, and do not let anyone else use this card**.

_________ You will use your personal needs money for your daily expenses such as food, clothing, haircut, cigarettes, entertainment, or any day-to-day expenses. **Before you go to a pawn shop, family, or a friend to barrow funds call us to check on your balance for additional funds needed.** Minka Inc. is not involved with any pawn shops or personal loans from family and/or friends. If you have any debts like this you will need to budget your personal needs money to make payments to these debts.

_________It is **your** responsibility to **contact each of your creditors and have your billing address changed to the address listed above.** Bills such as; utility, cell phone, cable, insurance, internet service etc. When changing the address, please make sure **your name remains on the bill,** and only the billing address is changed. Please **Do Not** add the company name **MINKA, Inc.**

_________Contact your landlord, and notify them that you now have a Representative Payee, and give them our contact information. Have your landlord send us a copy of your lease should you not have one. This may be faxed to our office. **F: (763) 441-4828**

_________It is very important that you keep in contact with our office. Any changes in your life, or your bills must be reported. Changes such as; Roommate moving in or out. Changing your cell phone or house phone number, or if you move to a new place. Also inform us of any family changes such as marriage or divorce, death or the birth of a child.

_________ Account statements are mailed out quarterly. If you have included an email address we are able to email them to you. Otherwise, they will be sent out using regular mail.

We are very happy to have you as a member of Minka Inc. Please contact us with any question or concerns you may have. The Minka Inc. staff is happy to assist you.

Christine Pastor
President/Owner
Minka, Inc.