Enrollment Form

Date: _______________

Client Information

Name: ____ Email Address ____________________________________

SSN: __________________________

Street Address: ______________________________________ City, State, Zip: ________________________

Phone: ___________________________________ Cell Phone: _______________________________

Name of apartment/facility/shelter: _____________________________________

Landlord Name: _________________________ Phone Number: ____________________________

Lives Alone: Yes/No

Name of Household Member: __________________ Relationship: ___________________________

Date of Birth: _________________ Place of Birth: ________________________

Mother's Maiden Name: ____

Father's First Name: ___________________________

Optional: Gender: _________ Race: ______________ Veteran _________ TBI ______

Benefits and/or Resources

Source & Amount: ___________ Source & Amount: _____________

Employed __________________ Rate of Pay ___________ Hours per Week _____ Start Date _______

Burial Plan or Life Insurance Policy: Yes/No ______________________

Checking/Savings Account ______________________ IRA/CD's/Bonds _____________

Car_______ Homeowner___________ Land_________

Case Management/Referral

Caseworker: _____________________________________ Agency: ___________________________________

Phone: _________________________________ Cell: ___________________________________

Fax: ___________________________________ Email: ____________________________________

Additional Information

Current Payee: _____________________________ Guardian: _________________________________

Entitled to Medicare: Part A _____ Part B _____ Part D_____ Name___________________________

Supplemental Insurance__________________________ QMB: Y / N

Entitled to Medicaid: ___________ Spend Down __________

Entitled to SNAP (Food Stamps): Yes/No Amount: _________

Other Assistance: ____

Notes:

____

P.O. Box 414711 · Kansas City, Missouri 64141

Phone: (816) 474-2972 · Fax: (816) 474-1673 · E-MAIL: BFMA@BFMA-KC.ORG

AGREEMENT OF FINANCIAL MANAGEMENT

I, ____, agree to have Budget and Financial Management Assistance (BFMA) deposit and manage my Social Security entitlement according to a budget developed in my best interest by a representative of BFMA.

I understand BFMA staff may be in consultation with my social service workers.

If needed, BFMA will consult with apartment managers, utility companies, and other creditors in order to formulate proper payment plans.

I agree to allow BFMA to release from my files all financial information required for the resolution of financial issues of my behalf.

I also understand that BFMA is allowed to charge a monthly fee of $44 or 10% (whichever is less) of my total monthly income.

This agreement is in effect from the date of the signature to the termination of services with BFMA.

____
Signature

____
Date

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Agreement Letter

The following is a list of things you as the client agree to do while working with BFMA. Please sign and return to BFMA.

- Treat staff with courtesy and respect.
- **Absolutely no client can come to BFMA's office, NO EXECPTIONS**
- Provide a receipt for request that are over $50.00
- No additional funds will go out if you have two or more receipts out
- All bills including but not limited to electric, gas, water, medical, credit cards, student loans, property taxes and probation and parole fees must be mailed to BFMA
- Notify your Financial Case Manager if you begin/stop working
- Pay stubs need to be sent to your Financial Case Manager at BFMA.
- Go over your budget with your Financial Case Manager prior to making any changes to your budget, for example changing cable service.
- If you receive re-certification letters from Medicaid, food stamps or housing BFMA must receive these items.
- Notify your Financial Case Manager of any changes with whom you live.
- If you intend to move, you must give your land lord a 30-day notice, and notify your BFMA Financial Case Manager prior to the move.
- **Call your Financial Case Manager at least once, every 30 days.**

____

Signature

____

Date

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Beneficiary Information

- Please provide us with the following information about the person you would like to name as your beneficiary.
- BFMA will not use the below information to discuss specific account information without client's consent.
- You may change this information at any time.
- You may also choose not to provide this information.

Name: ____

Street Address : ____

City, State & Zip Code: ____

Phone: ___________________________

Their relationship to you (parent, spouse, sibling, friend, etc):
____

Your signature: ____

Today's date: __________________

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BFMA
BUDGET AND FINANCIAL MANAGEMENT ASSISTANCE

Budget and Financial Management Assistance
Budget Development Form

Client Name: ________________________ Date: ____________________

Income Amount ___________________ Source: _______________
Amount ___________________ Source: _______________

Budget Monthly Income: __________________

Rent	
Electricity	
Gas	
Water	
Telephone	
Cable	
Insurance	
Bus Pass	
Other Transportation	
Medication	
Medical Bills	
Other	
Personal (laundry, hygiene)	
Groceries	
BFMA Service Fee	44
Total Regular Expenses	

Rent checks: ____________________
____
____
____

Past Bills: ______________________
____
____
____

Comments:
____
____
____
____
____
____

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Phone: (816) 474-2972 · Fax: (816) 474-1673 · E-MAIL: BFMA@BFMA-KC.ORG

Consent for Release of Information

I, ____, authorize

____
Name and title of person or organization to disclose information

____
Address

____
City State Zip Code

To disclose to: BFMA (Budget and Financial Management Assistance)
P.O. Box 414711
Kansas City, MO 64141
Tel. (816) 474-2972 Fax. (816) 474-1673

The following information:

My past and present financial status for the purpose of formulating a payment plan for the future. Please send future correspondence to me in care of BFMA.

____
Signature

____
Date

I ________________________________(CLIENT NAME) pay__________________________ (LANDLORD) rent

totaling $ __________ a month for living at:

____

ADDRESS CITY, STATE, ZIP

____

PHONE NUMBER (Landlord) EMAIL (Landlord)

Do other's live in the household? Yes ☐ No ☐ **Are the household members related?** Yes ☐ No ☐

Please list names and ages of household members:

____

____

Please include all other necessary notes below (such as if this rent includes utilities or groceries, etc…)

____

____

This agreement begins ____________________ (month/day/year) **and ends** ____________________(month/day/year)

____

Client Name Printed

____________________________________ ________________

Client Signature *Date*

____

Landlord Name Printed

____________________________________ ________________

Landlord Signature *Date*

Social Security Administration
Consent for Release of Information

Form Approved
OMB No. 0960-0566

You must complete all required fields. We will not honor your request unless all required fields are completed. *(*signifies a required field).*
TO: Social Security Administration

***My Full Name**	***My Date of Birth (MM/DD/YYYY)**	***My Social Security Number**

I authorize the Social Security Administration to release information or records about me to:

***NAME OF PERSON OR ORGANIZATION:**	***ADDRESS OF PERSON OR ORGANIZATION:**

***I want this information released because:** ______
We may charge a fee to release information for non-program purposes.

***Please release the following information selected from the list below:**
You must specify the records you are requesting by checking at least one box. We will not honor a request for "any and all records" or "my entire file." Also, we will not disclose records unless you include the applicable date ranges where requested.

- ☐ 1.Social Security Number
- ☐ 2.Current monthly Social Security benefit amount
- ☐ 3.Current monthly Supplemental Security Income payment amount
- ☐ 4.My benefit or payment amounts from date ______ to date ______
- ☐ 5.My Medicare entitlement from date ______ to date ______
- ☐ 6.Medical records from my claims folder(s) from date ______ to date ______
  If you want us to release a minor child's medical records, do not use this form. Instead, contact your local Social Security office.
- ☐ 7.Complete medical records from my claims folder(s)
- ☒ 8.Other record(s) from my file **(you must specify the records you are requesting, e.g., doctor report, application, determination or questionnaire)**

I AM AUTHORIZING SSA TO RELEASE MY MEDICAL DIAGNOSIS CODE TO BFMA

I am the individual, to whom the requested information or record applies, or the parent or legal guardian of a minor, or the legal guardian of a legally incompetent adult. I declare under penalty of perjury (28 CFR § 16.41(d)(2004)) that I have examined all the information on this form, and any accompanying statements or forms, and it is true and correct to the best of my knowledge. I understand that anyone who knowingly or willfully seeks or obtain access to records about another person under false pretenses is punishable by a fine of up to $5,000. I also understand that I must pay all applicable fees for requesting information for a non-program-related purpose.

***Signature:** ______ ***Date:** ______
***Address:** ______

Relationship (if not the subject of the record): ______ ***Daytime Phone:** ______

Witnesses must sign this form ONLY if the above signature is by mark (X). If signed by mark (X), two witnesses to the signing who know the signee must sign below and provide their full addresses. Please print the signee's name next to the mark (X) on the signature line above.

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)