BFMA
BUDGET AND FINANCIAL MANAGEMENT ASSISTANCE

Enrollment Form

Date: _____

Client Information

Name: _____
SSN: _____
Street Address: _____
City, State, Zip: _____
Phone: _____ Phone: _____
Name of apartment/facility/shelter: _____
Lives Alone: Yes/No
Name of Household Member: _____
Relationship: _____
Name of Household Member: _____
Relationship: _____
Date of Birth: _____ Place of Birth: _____
Mother's Maiden Name: _____
Diagnosis Code: _____
Optional: Gender: _____ Race: _____
Next of Kin/Beneficiary: _____

Benefits and/or Resources

Source & Amount: _____
Source & Amount: _____
Burial Plan or Life Insurance Policy: Yes/No
Comments: _____

Case Management/Referral

Caseworker: _____ Agency: _____
Phone: _____ Cell: _____
Fax: _____ **Email:** _____

Additional Information

Current Payee: _____
Guardian: _____
Entitled to Medicare: Part A _____ Part B _____
Entitled to Medicaid: _____
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

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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	41
Total Regular Expenses	

Rent checks: _____
_____
_____
_____

Past Bills: _____
_____
_____
_____

Comments:
_____
_____
_____
_____
_____
_____

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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 $41 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.
- Provide receipts for all money that is sent to you from 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.
- 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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BUDGET AND FINANCIAL MANAGEMENT ASSISTANCE

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.

Date_____

_____
Signature of Client

BFMA

BUDGET AND FINANCIAL MANAGEMENT ASSISTANCE

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

I,_____ (CLIENT), agree to

pay_____(LANDLORD) rent totaling $ _____ a month for living at:

_____

STREET ADDRESS

_____

CITY, STATE, ZIP

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 _____ **and ends** _____.
month/day/year 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

*SSA will not honor this form unless all required fields have been completed (*signifies required field).*

TO: Social Security Administration

*Name | *Date of Birth | *Social Security

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

*NAME	*ADDRESS
Budget & Financial Management (BFMA)	P.O. Box 414711, KC MO 64141

*I want this information released because:
I am authorizing SSA to release my medical diagnosis code to BFMA

There may be a charge for releasing information.

*Please release the following information selected from the list below:
You must check at least one box. Also, SSA will not disclose records unless applicable date ranges are included.

- ☐ Social Security Number
- ☐ Current monthly Social Security benefit amount
- ☐ Current monthly Supplemental Security Income payment amount
- ☐ My benefit/payment amounts from _____ to _____
- ☐ My Medicare entitlement from _____ to _____
- ☐ Medical records from my claims folder(s) from _____ to _____
  If you want SSA to release a minor's medical records, do not use this form but instead contact your local SSA office.
- ☐ Complete medical records from my claims folder(s)
- ☒ Other record(s) from my file (e.g. applications, questionnaires, consultative examination reports, determinations, etc.)
  I am authorizing SSA to release my medical diagnosis code to BFMA

I am the individual to whom the requested information/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 in accordance with 20 C.F.R. § 16.41(d)(2004) 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 or willfully seeking or obtaining access to records about another person under false pretenses is punishable by a fine of up to $5,000. I also understand that any applicable fees must be paid by me.

*Signature: _____ *Date: _____

Relationship *(if not the individual)*: _____ *Daytime Phone: _____