995 Worthington Street, Springfield, MA 01109
Telephone (413) 734-5376 FAX (413) 737-7949

Representative Payee Advocacy Agreement

I, ________________________ of ________________________ agree to act in an advocacy capacity for ______________________. As such, I understand that I am responsible for and agree to accept responsibility to provide Mental Health Association, Inc. (MHA), the representative payee for _______________________ , with financial information in order that MHA may properly administer the bank account for the above named participant. This information includes, but is not limited to the participant's financial obligations (including amounts and due dates), financial resources available (including other bank accounts and wage information, if any), and changes to the participant's finance plan as needed.

I further agree to be the liaison between MHA and the participant.

_____ All checks made payable to the participant will be forwarded to me at ______________ where they will be made available to the participant.
_____ All checks made payable to the participant may be sent directly to the participant at ____________________

I also agree to furnish MHA with the name of the new advocate if my role as advocate for this participant should discontinue for any reason.

Signed by:________________________________

Print Name: ______________________________

Date:____________________________________

Agency Name: ___________________________
Agency Address: _________________________
Agency Telephone: _______________________

Complete only if there is a Guardian for the above named participant:

I,_____________________________, guardian for ____________________agree to allow the above to make financial decisions for ___________________.

Guardian Signature: _______________________.