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

REPRESENTATIVE PAYEE SERVICES FEE AGREEMENT

I_____ agree to the transfer of Representative payee from

_____ to Mental Health Association, Inc. Representative Payee Service (RPS).

I furthermore agree to the fee proposed by MHA for the administration of my Social Security funds as representative payee (the lesser of $36.00/month or 10%).

I agree that I will have a liaison who will be the intermediary between MHA and myself and that I will make all requests to my liaison who will contact MHA with my requests. I understand that if I do not have a liaison that MHA may terminate this agreement.

_____ _____
Participant/Guardian Signature Date

I have fully explained the above information in a manner understood by the consenting party and have answered all questions to the best of my ability. It is my opinion that consent has been freely and knowingly given.

_____ _____
Signature and title of person obtaining consent Date