ALAMEDA COUNTY HEALTH CARE SERVICES AGENCY

BEHAVIORAL HEALTH CARE SERVICES

SUBSTITUTE PAYEE PRGORAM

Part I – Authorization for release of Information

Name: _____

SSN: _____

I hereby authorize the Social Security Administration, Railroad Retirement Board, Veterans Administration and Social Services Agency to release to Alameda County Health Care Services Agency all information in reference to my claim(s). Furthermore, I authorize Alameda County Behavioral Health Care Services Agency to exchange relevant mental health and financial information with these and other social services agencies concerning myself and treatment.

This authorization shall remain in force until revoked in writing by me.

Signature : _____

Date : _____

Part II – Authorization for Payeeship

Name : _____

SSN : _____

I agree to have Alameda County Behavioral Health Care Services Agency to act as my authorized representative and payee for my SSI/SSA and Medi-Cal benefits and for any other benefits for which I am entitled or for which I have applied.

Signature : _____

Date : _____

SIGNATURE NEEDED IN BOTH SECTIONS