Welcome to Tracy Stein Management Services, Inc.

Tracy Stein Management Services is delighted that you have chosen us to be your Financial Management Services provider. TSM has been providing services to participants of the State of California Self-Determination Pilot Project since its inception. It is with great excitement that we expand our services to include new participants as the program launches statewide.

Tracy Stein Management Services believes in and fully supports the "person centered approach" of the Self-Determination Program. We will work with you and your circle of support to safeguard your interests and manage your budgetary funds as outlined in your individual plan. We believe that you will find the service we provide to be personalized to meet your needs, efficient and accurate.

Please complete and return the attached Financial Management Services Agreement and Intake Packet to your Service Coordinator for processing.

Thank you again for choosing Tracy Stein Management Services and we look forward to being of service to you!

Danielle Robertson
Director

P.O. Box 580631 • Elk Grove, CA 95758 • 916-287-9146 • 916-399-9878 (Fax)
danielle@trustmgmtservices.com

Financial Management Services Agreement

Consumer Name: _____

Mailing Address: _____

City, State, Zip: _____

Phone Number: _____

Email: _____

Plan Dates: From _____ To _____
Month/Day/Year Month/Day/Year

Monthly Rate for FMS as Bill Payer:

1-3 Services - $50.00 per month
4-6 Services - $75.00 per month
7+ Services - $100.00 per month

- Monthly FMS Rate will be agreed upon based on the average number of services provided each month. The rate will be included in the Self-Directed Budget/Plan.

Services, Supports, Responsibilities of Financial Management Services

1. Receive and Account for Regional Center funding of Self-Directed budget.
2. Process vendor invoices & check requests through the DDS eBilling System to obtain budget funds from Regional Center.
3. Make disbursements per budget as outlined in Individual Program Plan.
4. Maintain receipts/supporting documentation for all disbursements.
5. Ensure providers are qualified to deliver services.
6. Mail Monthly Client Budget Reports to:
    a. Participant/Representative
    b. Regional Center
    c. Service Broker (if needed)

Completed by: _____

Signature: _____

TSM Self-Directed Services Intake Form

CONSUMER INFORMATION

_____
(Last Name) (First Name) (M.I.)

UCI: _____ DOB: _____

Address: _____

City, State, Zip: _____

Phone #: _____ **SSN#** _____ _____ _____
(Area Code-Phone #)

Email Address: _____

Plan Dates: From_____ To_____
Mo/Day/Yr Mo/Day/Yr

REGIONAL CENTER INFORMATION

RC Name: _____

RC Mailing Address: _____

City, State, Zip: _____

Service Coordinator: _____

SC Phone #: _____ SC Cell: _____
(Area Code-Phone #) (Area Code-Phone #)

SC Fax #**:** _____ Email: _____
(Area Code-Phone #)

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FAMILY INFORMATION

Family Name: _____
(Last) (First) (M.I.)

Family Address: _____

Family City, State, Zip: _____

Family Phone #: _____Family Cell #: _____
(Area Code-Phone #) (Area Code-Phone #)

Family Email Address: _____

Does Family member need copy of monthly reports? ____ Yes ____ No

BROKER INFORMATION

Broker Name: _____

Broker Mailing Address: _____

City, State, Zip: _____

Broker Phone #: _____ Cell: _____
(Area Code-Phone #) (Area Code-Phone #)

Fax **#:** _____ Email: _____
(Area Code-Phone #)

Does broker need copy of monthly reports? ____ Yes ____ No

COMPLETED BY:

Name: _____
(Please Print) (Date)

Signature: _____

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