



**AGREEMENT AND AUTHORIZATION
FOR NURSING HOME RESIDENTS**

Important Note: To help the government fight the funding of terrorism and money laundering activities, Federal law requires all financial institutions to obtain, verify and record information that identifies each person who opens an account.

What this means for you: When you open an account with us, we will ask for your name, address, date of birth, and other information that will allow us to identify you. We may also ask to see your driver's license or other identifying documents.

PART I. SPECIAL CHECKING ACCOUNT AGREEMENT

I, _____, the person signing this Agreement, am over 18 years old, and understand fully what I am signing. I am opening this account directly to you solely in my own name and as the sole owner of all the payments which will be sent directly to you for deposit in this account.

You can act under this agreement until I tell you in writing that this Agreement is ended. If I die, you can act under this Agreement until you are informed in writing of my death by my legal representative or the nursing Home, and you can then handle and pay out the money in the account at the time of my death to whoever has a legal right to the money.

I further understand that you will send me monthly statements indicating the receipt and dispersal of the funds in my account.

Signature of Resident or "X" and 2 Witnesses

Date

PART I - A. AUTHORIZATION TO TRANSFER MONEY IN ACCOUNT TO NURSING HOME

I authorize you to transfer all funds received on this account to the account of _____ either the 4th of the month, 2nd, 3rd or 4th Thursday of the month. It is understood and agreed that the transfers that take place under this agreement will be made in accordance with Social Security Personal needs requirements for a New Available Monthly Income and a Resident Living Allowance. Under this agreement, you are further authorized to establish an interest bearing account in my name with the facility. Funds not used to meet the Social Security requirements stated above will remain in an account in my name. It is understood that this agreement is being made in accordance to the above facility's policy for handling resident income.

Signature of Resident or "X" and 2 Witnesses

Date

PART II. CERTIFICATION

I hereby certify that I have read and understood this form. I further certify that I am entitled to the direct deposit payment of (CHECK ONE):

- Social Security
- Supplemental Security Income

In signing this form, I authorize my payment (s) to be sent to Amalgamated Bank to be deposited into the designated account.

Signature of Resident, Legal Representative
or "X" and 2 witnesses

Date