Representative Payee Services

Client Intake Packet

BENEFITS MANAGEMENT CORPORATION & LIFE

2640 Cordova Lane
Rancho Cordova, CA 95670
P.O. Box 168045 Sacramento, CA 95816

1047 North 4th Street
San Jose, CA 95112
PO. Box 11012 San Jose, CA 95103

Toll Free Phone: 866-622-3098
Toll Free FAX: 866-606-3248
Website: www.webpayee.com

Version 5.0 12-07-18

Benefits Management CORPORATION

Living In Familiar Environments

Benefits Management Corporation &
Living in Familiar Environments
2640 Cordova Lane • Rancho Cordova, CA 95670
1047 North 4th Street • San Jose, CA 95112
www.webpayee.com • Phone (866) 622-3098 • Fax (866) 606-3248

Instructions for Completing the Client Intake Packet

1. Complete all of the forms included in this document and ensure client signs where designated. (The Budget Worksheet is optional – See #5 below).

2. If this is the first time the client is applying for a Representative Payee, please download and complete the SSA 787 Form (Physician's Statement of Patient's Capability to Manage Benefits). If the Social Security Administration has already determined client must have a representative payee, completing a SSA-787 is not necessary.

3. Obtain and submit 2 forms of identification – (preferably 1 photo I.D. and 1 other form of I.D.)
   a. CA driver license
   b. CA Identification Card
   c. Social Security Card
   d. Veterans' Administration Identification

4. If possible, provide a copy of the client's Medicare/Medi-Cal Card.

5. In order to assist in developing an accurate budget, please provide copies of the following bills, if applicable:
   a. Lease/Rental agreement – it is ***vital*** we receive this document immediately. Without a rental agreement, Social Security benefits can be delayed.

   (If you do not have a rental agreement, you may download one from the resources page of our website. www.webpayee.com)

   b. Utilities such as SMUD and/or PG&E
   c. City or county water, sewer & garbage bills

6. You may complete and submit budget worksheet yourself/with your client. This is helpful if you/your client has bills such as cell phone or auto insurance that will be paid out of personal and incidental funds making it is necessary to have those funds dispersed at a particular time of month. The Benefits Management Corp/LIFE staff will review the worksheet you submit and work with you/your client if adjustments are necessary to ensure benefit lasts for the entire month.

7. Ensure client receives a copy of the last five pages of the intake packet for his/her records: *Client Agreement, Processes and Procedures, What Happens During Intake, What Happens After I Sign Up*

8. Fax the completed intake packet to: (866) 606-3248 or you may submit via email to: agency@webpayee.com.

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Client Intake Packet List

1. **BMC/LIFE Does not accept clients with the following items:** _____ (client's initials)
   a. Clients with a mortgage balance; or
   b. Clients with a large amount owed to personal back taxes.
   (Disclose all back owed tax details upfront to BMC/LIFE to determine eligibility)

2. **BMC/LIFE May accept clients with the following items after careful review of income to debt ratio and/or willingness or creditor to work within client's means:**

   _____ (client's initials)

   a. Property Tax on free and clear home
   b. Large unpaid medical bill

3. **BMC/LIFE Accepts clients with the following bills and <u>is RESPONSIBLE</u> for making payments if received in a timely manner:** ***(Please disclose any back owed amounts to BMC/LIFE upfront)***

   _____ (client's initials)

   a. Garbage Bill
   b. Land line Telephone Bill
   c. Medical Bill (i.e. pharmacy co-pays)
   d. PG&E account
   e. SMUD account
   f. Unpaid Fine

4. **BMC/LIFE accepts clients with the following bill and <u>CLIENT is RESPONSIBLE</u> for making payments:** _____ (client's initials)

   a. Auto Loan Payments
   b. Auto Insurance
   c. Cable Bill
   d. Cell Phone Bill
   e. Credit Card Bill
   f. Debt Collections
   g. Furniture Rentals
   h. Internet Bill
   i. Medical Bill (i.e. ambulance fees)
   j. Pawn Shop Loans
   k. Pay Day Loans
   l. Personal Storage Bill

NOTE: BMC/LIFE will make payments for clients who are supported closely by an agency, e.g. ALTA, Sutter Senior Care, or Solano County Mental Health. Please ask for more details.

CLIENT INTAKE

Date: _____

LAST NAME FIRST MI	SOCIAL SECURITY NUMBER
DATE OF BIRTH	PLACE OF BIRTH
CLIENT PHONE NUMBER	CLIENT EMAIL
REFERRING AGENCY	CASE MANAGER/SOCIAL WORKER NAME
CASE MANAGER/SOCIAL WORKER PHONE NUMBER	CASE MANAGER/SOCIAL WORKER EMAIL

LIVING ARRANGEMENT

Landlord/Facility Name	Move In Date
Street Address	Monthly Rent Amount
City, State, Zip Code	Living Arrangement Type
Landlord Phone #	Landlord Email

Do you live alone? Yes ☐ No ☐

If no, whom do you live with? (Please list additional people in notes)

NAME	RELATIONSHIP
NAME	RELATIONSHIP
NAME	RELATIONSHIP

NOTES:_____

INCARCERATION

JAIL / PRISON LOCATION: _____

DATE IN: _____ DATE OUT: _____

X-REF#: _____ CDC#: _____

PAROLE / PROBATION OFFICE NAME: _____

OFFICE TELEPHONE #: _____

SOCIAL SECURITY INFORMATION

BENEFITS: SSI: _____ SSA: _____

BLIND: YES ☐ NO ☐

FROM OUT OF STATE: YES ☐ NO ☐

DATE ENTERED STATE? _____ PROOF OF ENTRY: YES ☐ NO ☐

NOTES:

_____

_____

_____

OTHER BENEFITS

VA: $_____ CLAIM#: _____ RRR: $_____ CLAIM# _____

OTHER: NAME _____ $_____ CLAIM# _____

OTHER: NAME _____ $_____ CLAIM# _____

UNEARNED INCOME

CHECK ALL THAT APPLY

☐ PRIVATE PENSION/ANNUITIES ☐ AFDC / GA / FOODSTAMPS ☐ RENTAL INCOME

☐ UNEMPLOYMENT/WORKERS COMP ☐ ALIMONY ☐ CHILD SUPPORT

☐ DIVIDENDS ☐ ROYALTIES ☐ TRUST FUND

☐ OTHER (EXPLAIN): _____

WAGES

☐ YES ☐ NO EMPLOYER: _____

DATE OF EMPLOYMENT: _____

REMIND CLIENT TO TURN IN COPIES OF PAYSTUBS MONTHLY. IF NOT TURNED IN TO SSA, THIS MAY CAUSE AN OVERPAYMENT AND A LARGE WAGE ESTIMATE ON THE CLIENT'S RECORD. GIVE CLIENTS STAMPED ENVELOPES

RESOURCES

THE RESOURCE LIMIT IS $2000 FOR A SINGLE PERSON AND $3000 FOR A MARRIED COUPLE. THE LIMIT APPLIES TO SSI AND MEDI-CAL ONLY

(CHECK ALL THAT APPLY)

☐ CHECKING ACCOUNT ☐ SAVINGS ACCOUNT ☐ CREDIT UNION

☐ TRUST ☐ STOCKS / BONDS ☐ CHRISTMAS CLUB

☐ REAL ESTATE ☐ BURIAL PLOT ☐ LIFE INSURANCE

☐ CAR / MOTORCYCLE ☐ BOAT ☐ TRAILER

☐ MEDI-CAL ☐ ABLE ACCOUNT ☐ OTHER (EXPLAIN)

NOTES:

_____

_____

_____

WILL / BURIAL

☐ YES ☐ NO

(GET COPY OF INFO FOR FILE)

TYPE: _____

WHEN ESTABLISHED: _____

IRREVOCABLE: ☐ YES ☐ NO

VALUE: _____

NEXT OF KIN: _____ _____
NAME PHONE #

_____
RELATIONSHIP

CONSERVED

IS THE CLAIMANT CONSERVED? ☐ YES ☐ NO
(If yes, please provide conservator paperwork)

CONSERVATOR NAME: _____

CONSERVATOR ADDRESS: _____

CONSERVATOR EMAIL: _____

PHONE#: _____

MARITAL STATUS / CHILDREN

☐ SINGLE ☐ MARRIED (DATE: _____) ☐ SEPERATED (DATE: _____)

☐ DIVORCED (DATE: _____) ☐ ANNULLED (DATE: _____)

☐ WIDOWED (DATE: _____)

CHILDREN? YES ☐ NO ☐ IF YES, HOW MANY? _____

EMERGENCY CONTACTS

NAME	NAME
STREET ADDRESS	STREET ADDRESS
CITY / STATE / ZIP CODE	CITY / STATE / ZIP CODE
TELEPHONE	TELEPHONE
RELATIONSHIP	RELATIONSHIP

IDENTIFICATION

GET A COPY OF THE FOLLOWING FOR FILE:
(*IF APPLICABLE)*

☐ PHOTO ID ☐ SSA CARD ☐ VA ID

☐ MEDICARE/MEDI- CAL CARD ☐ OTHER ID

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CONSENT TO RELEASE INFORMATION

To: Benefits Management Corporation and Living in Familiar Environments

Name:_____ Date of Birth: _____

SSN: _____

I hereby give my consent to **Benefits Management Corp / LIFE** to obtain and/or exchange information for the purpose of either planning for my well-being and/or assuring my continuing eligibility for Social Security benefits.

I also hereby give my consent to **BMC** and **LIFE** to obtain and/or exchange information regarding the item(s) below for the purpose of planning for my well-being.

- ☐ Social Security Number
- ☐ Bank Account
- ☐ Medi-Cal
- ☐ O.H.S. Plan / Appointments
- ☐ Other:
- ☐ Account Ledger
- ☐ Burial Trust
- ☐ Wages/Employment
- ☐ Social History
- ☐ Monthly SSA/SSI Amount
- ☐ Utility Bills
- ☐ Address/Living Arrangement
- ☐ Facesheet

_____

_____

_____

I am the individual, to whom the requested information/records applies, or the parent or legal guardian of a minor, or the legal guardian of a legally incompetent adult. I declare that I have examined all of the information on this form, and on any accompanying statements or forms, and it is true and correct to the best of my knowledge. I understand that BMC / LIFE is not responsible if a person authorized to obtain information regarding my account does so with false pretenses and BMC / LIFE is not responsible for any effect to your benefits caused by releasing the requested information.

_____ _____
Print Name Date

_____ _____
Signature of Claimant or Legal Guardian Relationship (if not claimant)

_____ _____
L.I.F.E. Staff Member Date

Advance Notification of Representative Payment

Name of Wage Earner, Self-Employed Person or SSI Claimant	Social Security Number
Name of Beneficiary (if other than above)	Relationship to Wage Earner, Self-Employed Person or SSI Claimant

I understand and agree with the following.

Need for Representative Payee

The Social Security Administration (SSA) has decided that I need someone to manage my benefits. Because of this, SSA will send my benefits to a representative payee. It is the duty of the representative payee to use my benefits for my best interests.

Choice of Representative Payee

SSA has selected _____ to be my representative payee.

My Right to Appeal

I understand that I have the right to appeal SSA's decision. I can appeal the choice of who will be the representative payee. In most cases, I can also appeal the decision that I need a payee. If I appeal, I will have the right to review the evidence in file and submit new evidence. I understand that I can have a friend, lawyer or someone else to help me.

I understand that I must file an appeal within 60 days. If I file after the 60 day period, I must have a good reason for not having filed this appeal on time. I have to ask for the appeal in writing. I will contact an SSA office if I wish to appeal.

Signature	Date

Witnesses are required only if this statement has been signed by mark (X) above. If signed by mark (X), two witnesses to the signing who know the person making the statement must sign below, giving their full addresses.

1. Signature of Witness	2. Signature of Witness
Address (Number and Street, City, State and ZIP Code)	Address (Number and Street, City, State and ZIP Code)

Form **SSA-4164** (9-1994) (EF 8-2000)
Destroy prior editions

SOCIAL SECURITY ADMINISTRATION

Form Approved
OMB No. 0960-0707

AUTHORIZATION FOR THE SOCIAL SECURITY ADMINISTRATION TO OBTAIN PERSONAL INFORMATION

Authorizing Person (Person about whom information is being requested)	Social Security Number
Claimant/Beneficiary (If other than authorizing person)	Claimant's/Beneficiary's Social Security Number

I authorize any public or private custodian of records to disclose to the Social Security Administration any records or information about me. In the case of a minor or incapable person, I, as guardian or representative, authorize the same disclosure of records about the person I represent.

Authorizing Person's Signature	Date

Mailing Address	City and State	ZIP Code

Your authorization does not ordinarily have to be witnessed. However, if you have signed by mark (X), two witnesses to the signing who know you must sign below giving their full addresses.

1. Signature of Witness	2. Signature of Witness
Address (Number, Street, City, State, ZIP Code)	Address (Number, Street, City, State, ZIP Code)

Privacy Act Statement
Collection and Use of Personal Information

Sections 205(a) and 1631(e) of the Social Security Act, as amended, authorize us to collect this information. We will use the information you provide on this form to obtain information about you from any public or private custodian regarding your eligibility for Social Security benefits.

You do not have to provide us this information. Your responses are voluntary. However, failure to provide all or part of the information could prevent us from making an accurate and timely decision regarding your Social Security benefits.

We rarely use this information you supply for any purpose other than for reviewing your claim for Social Security benefits. However, we may use it for the administration and integrity of Social Security programs. We may also disclose information to another person or to another agency in accordance with approved routine uses, which include but are not limited to the following: 1. To enable a third party or an agency to assist Social Security in establishing rights to Social Security benefits and/or coverage; 2. To comply with Federal laws requiring the release of information from Social Security records (e.g., to the Government Accountability Office and Department of Veterans' Affairs); 3. To make determinations for eligibility in similar health and income maintenance programs at the Federal, State, and local level; and, 4. To facilitate statistical research, audit, or investigative activities necessary to assure the integrity and improvement of Social Security programs.

We may also use the information you provide in computer matching programs. Matching programs compare our records with records kept by other Federal, State, or local government agencies. Information from these matching programs can be used to establish or verify a person's eligibility for Federally-funded or administered benefit programs and for repayment of payments or delinquent debts under these programs.

A complete list of routine uses for this information are available in our System of Records Notices entitled, Claims Folders Systems (60-0089) and the Master Beneficiary Record (60-0090). These notices, additional information regarding this form, routine uses of information, and our programs and systems are available on-line at www.socialsecurity.gov or at your local Social Security office.

Paperwork Reduction Act Statement - This information collection meets the requirements of 44 U.S.C. § 3507, as amended by section 2 of the Paperwork Reduction Act of 1995. You do not need to answer these questions unless we display a valid Office of Management and Budget control number. We estimate that it will take about 5 minutes to read the instructions, gather the facts, and answer the questions. Send **only** comments on our time estimate above to: SSA, 6401 Security Blvd., Baltimore, MD 21235-6401.

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Budget Worksheet

Client Name: _____ SSI (T16): _____

SSN/TRUST:_____ SSA (T2): _____

Effective Date:_____ OTHER: _____

TOTAL: _____

TYPE	AMOUNT	DATE/FREQUENCY	VENDOR NAME
Rent			
Payee Fee			
P & I			
P & I			
Other/Misc			
Other/Misc			

Total: _____

Method in receiving personal needs ***(Please check one)***

☐ Checks only ☐ Life Freedom Prepaid Mastercard

☐ Private Bank Account (Please provide copy of a voided check/direct deposit slip)

Client Signature: _____ **Date:** _____

CLIENT AGREEMENT

Benefits Management Corporation and Living in Familiar Environments (BMC/LIFE) is here to serve you and administer your SSI/SSA benefits according to the Social Security Administration regulations. Once appointed as your representative payee, BMC/LIFE has no legal authority to manage non-Social Security income or medical matters *i.e. Medi-Cal*. (https://www.ssa.gov/payee/NewGuide/toc.htm)

Per Social Security Administration regulations, BMC/LIFE can collect a fee from the client's monthly benefits for serving as the client's representative payee.

BMC/LIFE does not issue emergency funds. As we have a policy in place stating current month's needs are for current month's benefits only.

PROCESSES AND PROCEDURES

Supplemental Security Income (SSI) is a needs-based benefit. That means that the amount of money for which you are eligible is based on three things:

1. Your living arrangements
2. Other income/benefits you may receive
3. Your total resources, which are things you own. (For example; bank accounts, stocks, bonds, homes, vehicles, jewelry, etc.)

Benefits Management Corporation (BMC) and Living in Familiar Environments (LIFE) will not be held responsible for any overpayments due to your failure to notify our office of changes. **Notification of changes must be submitted in writing.** This can be done in person by visiting our office, by fax, email, or by mailing a signed letter to BMC and LIFE.

IT IS VERY IMPORTANT TO NOTIFY US WITHIN 10 DAYS IF ANY OF THE ITEMS BELOW OCCUR:

RESIDENCE

- You move from your residence
- Someone permanently moves into or out of your residence
- You enter a locked facility, such as jail, prison, a hospital
    - **Note: If you fail to notify us by phone, email, or mail and money is issued for rent, utilities and other expenses; BMC and LIFE is not responsible for any overpayment that occurs.**
- You change your phone number
- You enter or leave a hospital or skilled nursing facility.
- You leave the state of California.

RESOURCES

- The amount of alimony or child support you receive changes
- You inherit or are given money
- You open or close a bank account, and if you receive interest on the account
- The amount of any benefit checks you receive directly changes
- You receive money from another source (VA, Railroad Retirement, or pension)
- Your benefit from another source stops

- You start or stop working
    - **Note: If you work, you must provide copies of your wages/check stubs to BMC/LIFE to submit to the Social Security Administration. If you do not provide copies of your wages/check stubs and are overpaid, BMC/LIFE will not be held responsible.**
- Purchase a burial plot or make burial arrangements
- Purchase a life insurance policy on yourself or someone else
- Buy or sell any auto, truck, boat, motorcycle, RV, etc.
- Buy or sell any real estate, including a house, condo or mobile home

WHAT HAPPENS DURING THE INTAKE INTERVIEW AT BENEFITS MANAGEMENT COPORATION AND LIVING IN FAMILIAR ENVIRONMENTS?

1. At the time of intake, the BMC/LIFE representative can tell you when BMC/LIFE will expect to receive your benefits; **it can take anywhere from 45-60 days from the date of applying.**

    - If the intake is completed before the Social Security Administration's cutoff date for the month (this is usually the third Friday of each month), BMC/LIFE should receive your benefits two months after applying for payee services.
    - If your benefits are in suspense, BMC/LIFE will work to get your benefits reinstated as quickly as possible.

2. You will be told who your temporary Account Manager is and you will be provided with the Account Manager's contact information. The Account Manager is the person you will speak with regarding your account while your account is getting established. You will need to notify your account manager in the event that any changes occur, such living arrangements, incomes changes, or new contact information.

3. Your Account Manager has a voicemail box and email for you to contact them. He or she will return your voicemail and/or email as soon as possible. It is important to leave full details on your voice message. Always leave your first and last name, full social security number, phone number where you can be reached, and detailed reason for your call. **PLEASE LEAVE ONLY ONE MESSAGE PER DAY AND ALLOW THE ACCOUNT MANAGER 24 HOURS TO RETURN YOUR CALL.** Leaving multiple messages will only delay your returned call.

4. The office lobby is open from 8:00am to 4:00pm Monday through Friday, closed during lunch from 12:00pm to 1:00pm, and closed on all federal holidays.

5. If possible, your budget is established at the time of the intake. If we are unable to establish a budget at the time of your intake, you will need to contact your Account Manager to do so before BMC/LIFE can release your funds. You will need to provide a copy of your rental agreement and bills that you would like BMC/LIFE to pay before payment can be made. **Note: You are responsible for paying your own telephone, cable, storage and insurance bills.**

WHAT HAPPENS AFTER I SIGN UP WITH BMC/LIFE PAYEE AGENCY?

1. If you need to speak to your Account Manager, call (866) 622-3098 Monday-Friday 8am-11am & 1pm-4pm.

2. You must have an appointment to meet with your Account Manager. You can schedule an appointment by calling or emailing your Account Manager or speaking with the Front Counter Staff in our office. **Same day appointments will not be scheduled.**

3. Once your budget is set for the month, you must follow the spending plan that is in place for that month. Any requests to change your budget for the following month must be submitted at least 5 days before the last business day of the current month.

4. Personal and Incidental funds are included in your monthly budget. If you have additional funds available after your budgeted expenses are set, you may request to have a portion of those funds issued to you.

   - You must complete an Expenditure Request Form if you are requesting funds in excess of $250. Please be ready to provide invoices/quotes upon making Expenditure Requests

   - **You must give your Account Manager 24-48 hours to process your request. It is not possible to approve requests immediately.**

   - You are required to submit receipts to show how the funds outside of your set budget are spent for any requests $100 and over.

5. You can receive your personal spending money via check mailed to your address or deposited to the LIFE Freedom Prepaid Master Card (Debit Card). Rent and vendor checks are mailed directly to the person to whom the check is made payable to.

6. Checks are mailed the day before their scheduled arrival. For example, if you are scheduled to receive a check on the first of the month, that check will be printed and mailed the business day before the first of the month.

7. You can have you utility bills mailed directly to one of the post office boxes possessed by BMC/LIFE for payment. Your name must be on the bill. **You are responsible for paying your own telephone, cable, storage and insurance bills.**

8. If you are homeless and do not have a mailing address, we encourage you to obtain a post office box. If you do not have a mailing address, we will recommend that you use the LIFE Freedom Prepaid Master Card to receive and use your personal spending money.

9. For your protection, you are the only person that can pick up your check. Vendor checks will not be released to clients. Vendor checks are mailed to the address BMC/LIFE has on file for that vendor.

10. BMC/LIFE is always closed the last business day off each month to prepare for the coming month.

11. BMC/LIFE observes all Federal holidays. If you are scheduled to receive a check on a holiday or a weekend, you should receive your check the business day before that holiday. **Note: Please allow 5-7 business days for the delivery of mailed checks.**

12. If you do not receive your check, it is your responsibility to report it lost or stolen immediately. We will place a stop payment and reissue the check. It takes **45 days** from the original check date to reissue another.

13. You are expected to be a good neighbor and responsible member of your community. We reserve the right to terminate payee services if we receive complaints that you've damaged property, are verbally or physically abusive to neighbors or other members of the community, or are appear to be chronically intoxicated or under the influence of drugs in public. Any funds remaining in your account will be returned to the Social Security Administration and we will close your account immediately.

14. BMC/LIFE will terminate payee services if a client is physically or verbally abusive to any BMC/LIFE staff, other clients or damages to the property. We reserve the right to charge you for any damages to our property. In the event this occurs, any funds remaining in your account will be returned to the Social Security Administration.

15. BMC/LIFE reserves the right to withhold a check or deposit from any client who appears to be intoxicated or under the influence of drugs. This policy is for our client's own protection.

I understand and agree to the above statements.

_____

Print Name

_____ _____

Client/Legal Guardian Signature **Date**

_____ _____

BMC/LIFE Staff Signature **Date**

PHYSICIAN'S/MEDICAL OFFICER'S STATEMENT OF PATIENT'S CAPABILITY TO MANAGE BENEFITS

Paperwork Reduction Act Statement - This information collection meets the requirements of 44 U. S.C. § 3507, as amended by Section 2 of the Paperwork Reduction Act of 1995. You do not need to answer these questions unless we display a valid Office of Management and Budget control number. We estimate that it will take about 10 minutes to read the instructions, gather the facts, and answer the questions. **SEND OR BRING THE COMPLETED FORM TO YOUR LOCAL SOCIAL SECURITY OFFICE. You can find your local Social Security office through SSA's website at www.socialsecurity.gov. Offices are also listed under U.S. Government agencies in your telephone directory or you may call Social Security at 1-800-772-1213 (TTY 1-800-325-0778).** ***Send only comments relating to our time estimate above to:*** *SSA, 6401 Security Blvd, Baltimore, MD 21235-6401.*

In replying, use this address:
SOCIAL SECURITY ADMINISTRATION

TELEPHONE NUMBER (Including Area Code)
( ) –

DATE

Privacy Act Statement

Sections 205(a) and 205(j), of the Social Security Act, as amended, authorize us to collect this information. The information is needed to make a determination regarding whether or not the named individual should be paid benefits directly or whether benefits should be paid to a representative payee. The information you furnish on this form is voluntary. However, failure to provide all or part of the information could prevent an accurate and timely decision on the proper payee for benefit receipt purposes.

We rarely use the information you supply for any purpose other than for making a determination on a claim. However, we may use it for the administration and integrity of Social Security programs. We may also disclose information to another person or to another agency in accordance with approved routine uses, which include but are not limited to: (1) to enable a third party or an agency to assist Social Security in establishing rights to Social Security benefits and/or coverage; (2) to comply with Federal laws requiring the release of information from Social Security records (e.g., to the Government Accountability Office and Department of Veteran Affairs); (3) to make determinations for eligibility in similar health and income maintenance programs at the Federal, state, and local level; and (4) to facilitate statistical research, audit or investigative activities necessary to assure the integrity of Social Security programs.

We may also use the information you provide in computer matching programs. Matching programs compare our records with records kept by other Federal, state or local government agencies. Information from these matching programs can be used to establish or verify a person's eligibility for Federally funded and administered benefit programs and for repayment of payments or delinquent debts under these programs.

A complete list of routine uses for this information is available in Systems of Record Notices 60-0089 and 60-0222. The notices, additional information regarding this form, and information regarding our programs and systems, are available on-line at www.socialsecurity.gov or at your local Social Security office.

SSA CONTACT

IDENTIFYING INFORMATION (SSA Only)
If different from patient

NAME OF WAGE EARNER OR SELF-EMPLOYED PERSON

SOCIAL SECURITY NUMBER
– –

PATIENT'S NAME		PATIENT'S ADDRESS (Number and Street, City, State, and ZIP Code)
PATIENT'S SOCIAL SECURITY NUMBER – –	PATIENT'S DATE OF BIRTH	

YOUR HELP IS NEEDED

The patient shown above has filed for or is receiving Social Security or Supplemental Security Income payments. We need you to complete the back of this form and return it to us in the enclosed envelope to help us decide if we should pay this person directly or if he or she needs a representative payee to handle the funds. Please Note: This determination affects how benefits are paid and has no bearing on disability determinations; SSA will NOT pay for this information. Thank you for your help.

WHO IS A REPRESENTATIVE PAYEE

A representative payee is someone who manages the patient's money to make sure the patient's needs are met. The payee has a strong and continuing interest in the patient's well-being and is usually a family member or close friend.

WHO NEEDS A REPRESENTATIVE PAYEE

Some individuals age 18 and older who have mental or physical impairments are not capable of handling their funds or directing others how to handle them to meet their basic needs, so we select a representative payee to receive their payments. Examples of impairments which may cause incapability are senility, severe brain damage or chronic schizophrenia. However, even though a person may need some assistance with such things as bill paying, etc., does not necessarily mean he/she cannot make decisions concerning basic needs and is incapable of managing his/her own money.

PLEASE COMPLETE THE INFORMATION ON THE REVERSE OF THIS FORM

PATIENT'S NAME		PATIENT'S ADDRESS (Number and Street, City, State, and ZIP Code)
PATIENT'S SOCIAL SECURITY NUMBER – –	PATIENT'S DATE OF BIRTH	

1. Date you last examined the patient _____

2. Do you believe the patient is capable of managing or directing the management of benefits in his or her own best interest?

By capable we mean that the patient:

- Is able to understand and act on the ordinary affairs of life, such as providing for own adequate food, housing, clothing, etc., and
- Is able, in spite of physical impairments, to manage funds or direct others how to manage them.

☐ Yes	☐ No	☐ Unsure
If "Yes", please omit question 3, but be sure to sign and date the form.	If "No", please provide a brief summary of the findings that led to this conclusion. Also, complete question 3.	If "unsure", please explain.

3. Do you expect the patient to be able to manage funds in the future (for example, the patient is temporarily unconscious)?

☐ Yes ☐ No

If yes, please explain.

NAME OF PHYSICIAN/MEDICAL OFFICER (Please print.)	TITLE
ADDRESS (Number and street, City, State, and ZIP Code)	TELEPHONE NUMBER *(Include Area Code)* ( ) –

I declare under penalty of perjury that I have examined all the information on this form, and on any accompanying statements or forms, and it is true and correct to the best of my knowledge. I understand that anyone who knowingly gives a false or misleading statement about a material fact in this information, or causes someone else to do so, commits a crime and may be sent to prison, or may face other penalties, or both.

SIGNATURE OF PHYSICIAN/ MEDICAL OFFICER	DATE