Payee Partners

PO Box 940
Chanhassen, MN 55317
Office 612-505-2758, Fax 612-662-0934

Representative Payee Participant Application Instructions

- Complete all questions on the intake form
- Read and Understand the Participant Agreement before signing
- Release Form – Identify individuals Payee Partners can discuss your information
- Complete SSA-4164 Advance Notification of Representative payment form
- Complete SSA-787 Physician Statement (needed if no previous payee)
- Submit a copy of rental lease agreement, contract or mortgage
- Submit a copy of renters or home insurance policy
- Submit a copy of automobile loan or lease agreement and insurance policy
- Submit a copy of Court Guardianship Letters
- Submit a copy of signed POA document
- Submit a statement from other expenses (utilities, phone, internet, etc..)

Please complete in full and send to <u>one</u> of the following:

1) allen@payeepartners.org – send request for encrypted mail

2) Fax 612-662-0934

3) Payee Partners
   PO Box 940
   Chanhassen, MN 55317

Participant Intake Form

General Information Today's Date:_____

Participant's Full Name: _____

Address: _____

City, State, Zip Code: _____

Phone Number: _____ Email: _____

Social Security Number: _____ Date of Birth: _____/_____/_____

Sex: Male / Female City and State of Birth: _____

Mother's Maiden Name: _____ Fathers Name: _____

Marital Status: _____ Spouse's Name (if Married): _____

Guardian Name: _____ Phone: _____

Guardian Email: _____Date of Appointment: _____

Guardian Address: _____

Court File Number: _____ (Please submit court letters with Intake Form)

Emergency Contact: _____

Emergency Phone: _____Emergency Email: _____

Do you have a Rep Payee?_____ If No, please submit physician's statement: SSA-787

Current Rep Payee Name: _____ Phone Number: _____

Current Rep Payee Address: _____

Please explain why a Rep Payee is needed (include medical diagnosis, Financial assistance or please describe. Use separate sheet if necessary):

_____

_____

Next of Kin Contact: _____

Next of Kin Phone: _____Next of Kin Email: _____

Doctor's Name and Phone number: _____

County Contacts

County Name: _____

Financial Worker Name: _____ Phone: _____

Financial Worker Email: _____

Case Manager Name: _____ Phone: _____

Case Manager Email: _____

Monthly Income

SSI $_____ RSDI $_____ MSA $_____ Food Stamps $_____

VA $_____ Wages $_____ Other $ _____

Employment Status:_____ Employer Name: _____

Monthly Expenses

Rent:_____ Garage / Storage: _____ Phone: _____ Cable: _____

Renter Insurance:_____ Car Payment: _____ Car Insurance:_____

Personal Needs: _____ - Circle One: [Check] [Re-Loadable Debit Card ($4)] [Direct Deposit]

Complete if Direct Deposit is selected:

Bank Name:_____ Routing Number:_____

Account Number:_____ Circle One: [Checking] [Savings]

Utilities not included with rent: _____

Car Insurance Company and Policy Number: _____

Child Support / Alimony: _____

Medical Expenses / Copayments: _____ MA Number: _____

Other Expenses (describe): _____

Other Expenses (describe): _____

Other Expenses (describe): _____

Housing

Move in Date: _____ Damage Deposit: _____

Name and relationship of individuals sharing residence: _____

_____

Landlord Name:_____ Phone: _____

Landlord Address: _____

City, State, Zip Code: _____

Additional Information

List pertinent information: _____

_____

_____

_____

Name and contact information of person completing this intake form: _____

_____

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Participant Agreement

Participation with Payee Partners Representative Payee services is voluntary for all Participants.

By signing this Agreement, you:

1. Are seeking to voluntarily request Representative Payee services offered through Payee Partners.

2. Agree you have received, read, understood and fully completed the intake forms.

3. Agree to promptly share all changes in your personal status, employment, residency and financial information with Payee Partners.

4. Authorize Payee Partners to receive the current social security approved monthly fee for providing representative payee services on your behalf.

5. Understand that Payee Partners will file the required documents to become your representative as soon as all information has been received from you. Once the documents have been filed with Social Security the authorization processing may take several months depending on their workload and validity of the information received. Upon our receipt of written notification from the Social Security Administration you will be informed.

6. Understand that once Payee Partners has been authorized to become your Representative Payee, your funds will be deposited to a bank account that is controlled and managed by Payee Partners.

7. If there is a financial emergency call the office to leave a detailed message that includes the situation for which the money is needed, the amount you are requesting and a telephone number where you can be reached. You will not receive a return call nor will any action be initiated without receiving a detailed message.

8. Agree to contact the vendor(s) to change the billing address to:
   Participant Name
   PO Box 940
   Chanhassen, MN 55317

9. Provide all necessary information in a timely manner

If you understand and accept the above statements and wish to enroll for Representative Payee services provided by Payee Partners, please sign and date this form.

_____ _____/_____/_____

Participant Signature Date

Participant Authorization for Release of Information Form

Payee Partners
PO Box 940
Chanhassen, MN 55317
Office 612-505-2758, Fax 612-662-0934

I, _____, give Payee Partners my permission to discuss and share information about the activities of my Representative Payee account ONLY to the following individuals:
(Print Name)

_____ _____
(Name) (Relationship)

_____ _____
(Name) (Relationship)

_____ _____
(Name) (Relationship)

_____ _____
(Name) (Relationship)

_____ _____
(Name) (Relationship)

_____ _____
(Signature) Date

_____ _____
Witness Signature only if participant cannot sign or uses a mark Date

This authorization is valid until such time as I revoke or change a name.

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 Payee Partners 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 (5-2005)
Destroy Prior Editions

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Social Security Administration

TOE 250

Form A
OMB No

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

TIME IT TAKES TO COMPLETE THIS FORM
We estimate that it ill take you about 5 minutes to complete this form. This includes the time it will take to read the instructions, gather the necessary facts and fill out the form. If you have comments or suggestions on this estimate, or on any other aspect of this form write to the Social Security Administration, ATTN: Reports Clearance Officer, 1-A-21 Operations Bldg., Baltimore, MD 21235-0001, And to the Office of Management and Budget, Paperwork Reduction Project (0960-0024), Washington, D.C. 20503. **Send only comments relating to our estimate or other aspects of this form to the offices listed above. All requests for Social Security cards and other claims-related information should be sent to your local social Security office, whose address is listed in your telephone directory under the Department of Health and Human Services.**

In Replying use this address:
SOCIAL SECURITY ADMINISTRATION

TELEPHONE NUMBER (Including Area Code)
( )

DATE

SSA CONTACT

This report is authorized by sections 205(a) and 205 (j) of the Social Security Act, as amended (42 U.S.C.) 405(a) and 405(j). While you are not required to respond, your cooperation will help us decide whether any Social Security benefits that may be due should be paid directly to the patient or to someone else on the patient's behalf. Your cooperation in completing and returning this statement will be appreciated.

We may also use the information you give us when we match records by computer. Matching programs compare our records with those of other Federal, State, or local government agencies. Many agencies may use matching programs to find or prove that a person qualifies for benefits paid by the Federal government. The law allows us to do this even if you do not agree to it. These and other reasons why information your provide may be used or given out are explained in the Federal Register. If you want to learn more about this, contact any Social Security office.

IDENTIFYING INFORMATION (SSA or
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. 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

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 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 sigh 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.

HEREBY CERTIFY THAT THE ABOVE STATEMENTS AND ANSWERS ARE TRUE TO THE BEST OF MY KNOWLEDGE.

NAME OF PHYSICIAN/MEDICAL OFFICER *(Please print)*	TITLE
ADDRESS *(Number and street, City, State, And ZIP Code)*	TELEPHONE NUMBER *(Including Area Code)* ( )
NATURE OF PHYSICIAN/MEDICAL OFFICER	DATE

*U.S. Government Printing Office: 1994 --300-948/00029