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

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**Representative Payee Participant Application Instructions**

- Download and 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..)

Before completing the intake form, ensure your address is within our 75 mile service area. A map is located on our website.

Please submit the completed intake form and send to one 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): \_\_\_\_\_

Name and SS # of person(s) for whom you are filing (the claimant), if different from above:  
\_\_\_\_\_

Guardian Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Guardian Email: \_\_\_\_\_ Date of Appointment: \_\_\_\_\_

Guardian Address: \_\_\_\_\_

Court Case Number – Please attach Court Letters: \_\_\_\_\_

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 Representative Payee is needed (include medical diagnosis, Financial assistance or please describe. Use separate sheet if necessary:

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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: \_\_\_\_\_

Relationship and contact information of other 'Interested Parties' not listed above:

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Monthly Income

SSI \$ \_\_\_\_\_ RSDI \$ \_\_\_\_\_ MSA \$ \_\_\_\_\_ Food Stamps \$ \_\_\_\_\_

VA \$ \_\_\_\_\_ Wages \$ \_\_\_\_\_ Other \$ \_\_\_\_\_

Employed: Yes / No      Employer Name and Address: \_\_\_\_\_

Monthly Expenses

Rent: \_\_\_\_\_ Garage / Storage: \_\_\_\_\_ Phone: \_\_\_\_\_ Internet: \_\_\_\_\_

Renter Insurance: \_\_\_\_\_ Car Payment: \_\_\_\_\_ Car Insurance: \_\_\_\_\_

Personal Needs: \_\_\_\_\_

3 Options to receive, circle one: [Check]    [Re-Loadable Debit Card (\$6)]    [Direct Deposit]

Complete if Direct Deposit is selected:

Bank Name: \_\_\_\_\_ Routing Number: \_\_\_\_\_

Account Number: \_\_\_\_\_ Circle One: [Checking] [Savings]

Utilities not included with rent and not listed above: \_\_\_\_\_

Car Insurance Company and Policy Number: \_\_\_\_\_

Child Support / Alimony: \_\_\_\_\_

Medical Expenses / Copayments: \_\_\_\_\_ MA Number: \_\_\_\_\_

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: \_\_\_\_\_

Are you planning to move within the next year? \_\_\_\_\_ If yes, please explain:

\_\_\_\_\_

\_\_\_\_\_

Additional Information

List pertinent information:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Name and contact information of person completing this intake form:

\_\_\_\_\_

# Participant Agreement

**Payee Partners**  
PO BOX 940  
CHANHASSEN MN 55317  
Office 612-505-2758, Fax 612-662-0934

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. Agree that Payee Partners is not responsible for completing, managing or submitting government benefit forms. Upon your request, Payee Partners will provide information regarding the social security benefit, account balance and monthly budget within 4 business days.

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**

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**Payee Partners**

PO Box 940

Chanhasen, MN 55317

Office 612-505-2758, Fax 612-662-0934

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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)

\_\_\_\_\_  
(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.

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## Advance Notification of Representative Payment

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Name of Wage Earner, Self-Employed Person or  
SSI Claimant

Social Security Number

- -

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Name of Beneficiary (if other than above)

Relationship to Wage  
Earner, Self-Employed  
Person or SSI Claimant

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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.

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Signature

Date

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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

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Address (Number and Street, City, State and ZIP Code)

Address (Number and Street, City, State and ZIP Code)

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

**TIME IT TAKES TO COMPLETE THIS FORM**

We estimate that it will 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.

IDENTIFYING INFORMATION (SSA or  
If different from patient

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.

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**

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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 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.

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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.

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**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