

MIRCI

Mental Illness Recovery
Center, Inc.

Representative Payee Program Referral Form

Client's Name: _____

DMH Record #: _____

Address: _____

Date of Birth: _____

SS #: _____

Telephone #: _____

Case Manager's Name: _____

Client's Income Source and Amount: _____

Is there a Court Appointed/Legal Representative? If YES, please state person's name and
address: _____

Is the Client's living arrangement likely to change in the next 12 months?
_____ Yes _____ No

Check the Reason(s) for Referral:

Absence of money management skills: _____ Substance Abuse: _____

At risk for exploitation by others: _____ Intellectual impairment: _____

Psychiatric impairment: _____

Unavailability of appropriate payee: _____ HS Client: _____

Physically impaired: _____

Other (please elaborate): _____

REQUEST TO BE SELECTED AS PAYEE	FOR SSA USE ONLY								FOR SSA USE ONLY
	Name or Bene. Sym.	Program	Date of Birth	Type	Gdn.	Cus.	Inst.	Nam.	
								DISTRICT OFFICE CODE	
								STATE AND COUNTY CODE:	

PRINT IN INK:

The name of the NUMBER HOLDER	SOCIAL SECURITY NUMBER
The name of the PERSON(S) (if different from above) for whom you are filing (the "claimant(s)")	SOCIAL SECURITY NUMBER(S)

Answer item 1 ONLY if you are the claimant and want your benefits paid directly to you.

1. I request that I be paid directly.
CHECK HERE and answer only items 3, 5, 6, and 8 before signing the form on page 4.

I REQUEST THAT THE SOCIAL SECURITY, SUPPLEMENTAL SECURITY INCOME, BLACK LUNG OR SPECIAL VETERANS BENEFITS FOR THE CLAIMANT(S) NAMED ABOVE BE PAID TO ME AS REPRESENTATIVE PAYEE.

2. Explain why you think the claimant is not able to handle his/her own benefits. (In your answer, describe how he/she manages any money he/she receives now.)

 Claimant is a minor child.

3. Explain why you would be the best representative payee. (Use Remarks if you need more space.)

4. If you are appointed payee, how will you know about the claimant's needs?
 Live with me or in the institution I represent.
 Daily visits.
 Visits at least once a week.
 By other means. Explain:

5. Does the claimant have a court-appointed legal guardian? YES NO
 IF YES, enter the legal guardian's:
 NAME _____
 ADDRESS _____
 PHONE NUMBER _____
 TITLE _____
 DATE OF APPOINTMENT _____

Explain the circumstances of the appointment. (Use remarks if you need more space.)

6. (a) Where does the claimant live?

- Alone
- In my home (Go to (b).)
- With a relative (Go to (b).)
- With someone else (Go to (b).)
- In a board and care facility (Go to (b).)
- In a public institution (Go to (c).)
- In a private institution (Go to (c).)
- In a nursing home (Go to (c).)
- In the institution I represent (Go to (c).)

(b) Enter the names and relationships of any other people who live with the claimant.

NAME	RELATIONSHIP

(c) Enter the claimant's residence and mailing addresses (if different from yours).

Residence: _____ Mailing: _____ Telephone Number: _____

(d) Do you expect the claimant's living arrangements to change in the next year?

- YES NO If YES, explain what changes are expected and when they will occur. (Use Remarks if you need more space.)

7. If you are applying on behalf of minor child(ren) and you are not the parent,

Does the child(ren) have a living natural or adoptive parent? YES NO

If YES, enter: (a) Name of parent _____

(b) Address of parent _____

(c) Telephone number _____

(d) Does the parent show interest in the child? YES NO

Please explain. _____

8. List the names and relationship of any (other) relatives or close friends who have provided support and/or show active interest with the claimant. Describe the type and amount of support and/or how interest is displayed.

NAME	ADDRESS/PHONE NO.	RELATIONSHIP	DESCRIBE SUPPORT/INTEREST

9. Check the block that describes your relationship to the claimant.

(a) Official of bank, agency or institution with responsibility for the person. Enter below which you represent:

- Bank
- Social Agency
- Public Official
- Institution:
 - Federal
 - State/Local
 - Private non-profit
 - Private proprietary institution. Is the institution licensed under State law? YES NO

IF (a) ABOVE CHECKED, COMPLETE ONLY QUESTIONS 10 AND 11 AND SIGN THE FORM ON PAGE 4.

(b) Parent

(c) Spouse

(d) Other Relative - Specify _____

(e) Legal Representative

(f) Board and Care Home Operator

(g) Other Individual - Specify _____

IF (b), (c), (d), or (e) ABOVE CHECKED, GO ON TO QUESTION 12

INFORMATION ABOUT INSTITUTIONS, AGENCIES AND BANKS APPLYING TO BE REPRESENTATIVE PAYEE

10. (a) Enter the name of the institution _____
(b) Enter the EIN of the institution _____

11. Is the claimant indebted to your institution for past care and maintenance? YES NO
If YES, give the amount of the debt, the date(s) the debt was incurred and the description of the debt.

INFORMATION ABOUT INDIVIDUALS APPLYING TO BE REPRESENTATIVE PAYEE

12. Enter: YOUR NAME _____
DATE OF BIRTH _____
SOCIAL SECURITY NUMBER _____
ANY OTHER NAME YOU HAVE USED _____
OTHER SSN'S YOU HAVE USED _____

13. How long have you known the claimant? _____

14. Does the claimant owe you any money now or will he/she owe you money in the future? YES NO
If YES, enter the amount he/she owes you, the date(s) the debt was/will be incurred and describe why the debt was/will be incurred.

15. If the claimant lives with you, who takes care of the claimant when work or other activity takes you away from home? What is his/her relationship to the claimant?

16. (a) Main source of your income
 Employed (answer (b) below)
 Self-employed (Type of Business _____)
 Social Security or Black Lung benefits (Claim Number _____)
 Pension (describe _____)
 Supplemental Security Income payments (Claim Number _____)
 AFDC (County & State _____)
 Other Welfare (describe _____)
 Other (describe _____)

(b) Enter your employer's name and address:

How long have you been employed by this employer? _____
(If less than 1 year, enter name and address of previous employer in Remarks.)

17. (a) Have you ever been convicted of a felony? YES NO
If YES: What was the crime? _____
On what date were you convicted? _____
What was your sentence? _____
If imprisoned, when were you released? _____
If probation was ordered, when did/will your probation end? _____

(b) Have you ever been convicted of any offense under federal or state law which resulted in imprisonment for more than one year? YES NO
If YES: What was the crime? _____
On what date were you convicted? _____
What was your sentence? _____
If imprisoned, when were you released? _____
If probation was ordered, when did/will your probation end? _____

18.	Do you have any unsatisfied FELONY warrants (or in jurisdictions that do not define crimes as felonies, a crime punishable by death or imprisonment exceeding 1 year) for your arrest? <input type="checkbox"/> YES <input type="checkbox"/> NO
	If YES: Date of Warrant _____ State where warrant was issued _____
19.	How long have you lived at your current address? (Give Date MM/YY) (If less than 1 year, enter previous address in Remarks) _____

REMARKS: *(This space may be used for explaining any answers to the questions. If you need more space, attach a separate sheet.)*

PLEASE READ THE FOLLOWING INFORMATION CAREFULLY BEFORE SIGNING THIS FORM

I/my organization:

- Must use all payments made to me/my organization as the representative payee for the claimant's current needs or (if not currently needed) save them for his/her future needs.
- May be held liable for repayment if I/my organization misuse the payments or if I/my organization am/is at fault for any overpayment of benefits.
- May be punished under Federal law by fine, imprisonment or both if I/my organization am/is found guilty of misuse of Social Security or SSI benefits.

I/my organization will:

- Use the payments for the claimant's current needs and save any currently unneeded benefits for future use.
- File an accounting report on how the payments were used, and make all supporting records available for review if requested by the Social Security Administration.
- Reimburse the amount of any loss suffered by any claimant due to misuse of Social Security or SSI funds by me/my organization.
- Notify the Social Security Administration when the claimant dies, leaves my/my organization's custody or otherwise changes his/her living arrangements or he/she is no longer my/my organization's responsibility.
- Comply with the conditions for reporting certain events (listed on the attached sheets(s) which I/my organization will keep for my/my organization's records) and for returning checks the claimant is not due.
- File an annual report of earnings if required.
- Notify the Social Security Administration as soon as I/my organization can no longer act as representative payee or the claimant no longer needs a payee.

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.

SIGNATURE OF APPLICANT	DATE <i>(Month, day, year)</i>
Signature <i>(First name, middle initial, last name)</i> <i>(Write in ink)</i>	Telephone number(s) at Which You May Be Contacted During the Day
SIGN HERE	

Print Your Name & Title *(if a representative or employee of an institution/organization)*

Mailing Address *(Number and street, Apt. No., P.O. Box, or Rural Route)*

City and State	Zip Code	Name of County
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Residence Address *(Number and street, Apt. No., P.O. Box, or Rural Route)*

City and State	Zip Code	Name of County
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Witnesses are only required if this application has been signed by mark (X) above. If signed by mark (X), two witnesses to the signing who know the applicant making the request must sign below, giving their full addresses.

1. SIGNATURE OF WITNESS	2. SIGNATURE OF WITNESS
ADDRESS <i>(Number and street, City, State and ZIP Code)</i>	ADDRESS <i>(Number and street, City, State and ZIP Code)</i>

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

<p>PAPERWORK REDUCTION ACT:</p> <p>This information collection meets the clearance requirements of 44 U.S.C. §3507, as amended by Section 2 of the Paperwork Reduction Act of 1995. You are not required to answer these questions unless we display a valid Office of Management and Budget control number. We estimate that it will take you about 10 minutes to read the instructions, gather the necessary facts, and answer the questions.</p>	<p>In replying, use this address: SOCIAL SECURITY ADMINISTRATION</p>
<p>■</p>	<p>TELEPHONE NUMBER (Include Area Code) ()</p> <p>DATE</p> <p>SSA CONTACT</p>
<p>Privacy Act: 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.</p> <p>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. Explanations about these and other reasons why information you provide may be used or given out are available in Social Security Offices. If you want to learn more about this, contact any Social Security Office.</p>	<p>IDENTIFYING INFORMATION (SSA Only) If different from patient</p> <p>NAME OF WAGE EARNER OR SELF-EMPLOYED PERSON</p> <p>SOCIAL SECURITY NUMBER _____ / _____ / _____</p>
<p>PATIENT'S NAME</p>	<p>PATIENT'S ADDRESS (Number and Street, City, State, and ZIP Code)</p>
<p>PATIENT'S SOCIAL SECURITY NUMBER _____ / _____ / _____</p>	<p>PATIENT'S DATE OF BIRTH</p>

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 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