TSUNAMI ENTERPRISES

COMPLETE INTAKE PACKET

If you would like to refer a client to us, all you need to do is complete our Intake Packet as well as SSA Form 787 & Form 795. Once you return those to us, we complete our SSA form & submit the combined packet to SSA for approval. SSA processing times are anywhere from 4 weeks to 6 months – we hope for the best but have no control.

The Physicians Statement & Statement of Claimant are **VERY IMPORTANT & BOTH ARE MANDATORY**.

* The Physicians Statement needs to give clear reasons why the client is no longer capable of managing their own finances (i.e., mental, physical, or cognitive impairment) and must be signed by a licensed physician, psychologist, or other qualified medical practitioner who has examined or treated the client, or by someone authorized to provide such certifications (e.g., a medical records librarian). This professional must have sufficient knowledge of the client's medical condition to make a meaningful assessment as to their impairment and lack of capacity.

  (Note: If the client already has a SSA Payee and is simply switching to Tsunami, no Physicians Statement is required)

* The Statement of Claimant needs to state that the client themselves (or their court-appointed conservator if applicable) feels they are no longer able to manage their finances due to (mental, physical, or cognitive) impairment and would like Tsunami Enterprises to be their Payee. Case Managers can also complete a Statement of Claimant to add information regarding housing instability due to lack of rent payments, shut-off notices being received for utilities, past financial abuse victimization, poor decision-making skills, etc. The more supporting information the better.

PO Box 6189, Santa Rosa, CA 95406 | P: 707.463.2546 | F: 707.463.6235
Email completed Intake Packets to maryf@tsunami-enterprises.org

Tsunami Enterprises

PO Box 6189, Santa Rosa, CA 95406
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www.tsunami-enterprises.org

Date Recv'd	Recv'd By

Social Security Intake Form

SSN #: ☐☐☐ - ☐☐ - ☐☐☐☐

☐ SSA / SSDI
☐ SSI
☐ VA / Pension
☐ Other: _____

TSUNAMI USE ONLY	Pre-Note Recv'd	Benefits Recv'd	Rep Payee Assigned	Entered in TRP

WE LOOK FORWARD TO PARTNERING WITH YOU

BASIC CLIENT INFORMATION

Client's Full Name: _____
Physical Address: _____
City: _____ State: _____ Zip: _____
Home Phone #: ( ) _____ Cell Phone #: ( ) _____
Mailing Address: _____
City: _____ State: _____ Zip: _____

How long has Client been at this address? _____ # Years _____ # Months
Previous Address *(if less than 2 months)* : _____
City: _____ State: _____ Zip: _____

Date of Birth: / / City & Sate of Birth: _____
Country of Birth *(if not USA)* : _____

Mother's Maiden Name: _____
Father's Full Name: _____

Was Client disabled before age 22? ☐ Yes ☐ No At what age? _____

Former Payee: _____
Mailing Address: _____
City: _____ State: _____ Zip: _____
Work Phone #: ( ) _____ Cell Phone #: ( ) _____

Emergency Contact: _____ Relation: _____
Mailing Address: _____
City: _____ State: _____ Zip: _____
Home Phone #: ( ) _____ Cell Phone #: ( ) _____

Referring Agency: _____
Contact Name: _____
Work Phone #: ( ) _____ Cell Phone #: ( ) _____

Who is paying the Payee Fee? ☐ Client ☐ Other: ***(attach POS)*** _____

Is the Client Conserved? ☐ Yes ☐ No County: _____
Conservator Name: _____
Work Phone #: ( ) _____ Cell Phone #: ( ) _____
***** Please provide complete conservatorship documentation including relevant court orders.***

Client's Living Situation: ☐ Alone ☐ Homeless ☐ Facility
☐ With Someone (spouse / partner / parents / siblings / relative / friend / etc.)

use REMARKS section if you need more space

Name (1): _____
Relationship: _____
Name (2): _____
Relationship: _____

Client's Share of Monthly Rent: $ _____
Landlord Name: _____
Facility License #: _____ *(if applicable)*
Mailing Address: _____
City: _____ State: _____ Zip: _____
Work Phone #: ( ) _____ Cell Phone #: ( ) _____

Does Client have access to cooking facilities? ☐ Yes ☐ No
Does Client have access to a refrigerator? ☐ Yes ☐ No

If NO, complete CA Meal Allowance Form

Current Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Annulled ☐ Widowed

Has Client ever been married? ☐ Yes ☐ No # of Marriages: _____

Name of Spouse: _____
Date of Marriage: / / to / /
City & State of Marriage: _____
Were any children born of this marriage? ☐ Yes ☐ No # of Children: _____
Did this marriage last longer than 10 years? ☐ Yes ☐ No
Did this marriage end due to death of Spouse? ☐ Yes ☐ No
Did this marriage last for the 9 months preceding death? ☐ Yes ☐ No

CLIENT FINANCIAL INFORMATION

Does Client have any **PERSONAL BANK ACCOUNTS**?

☐ Checking Acct #: _____ Bank: _____
☐ Savings Acct #: _____ Bank: _____
☐ CalABLE Acct #: _____ Opened: _____
☐ Special Needs Trust *(attach documentation & latest statement)* Opened: _____

Unearned Income? ☐ Yes ☐ No

PLEASE CHECK ALL THAT APPLY

☐ Private Pension $ _____
☐ Unemployment $ _____
☐ Dividends $ _____
☐ General Assistance $ _____
☐ Alimony / Child Support $ _____
☐ Rental Income $ _____
☐ Gambling / Lottery $ _____

Additional Resources? ☐ Yes ☐ No

PLEASE CHECK ALL THAT APPLY

☐ Stocks / Bonds / Trust $ _____
☐ Real Estate $ _____
☐ Life Insurance $ _____
☐ Burial Plot $ _____
☐ Car / Boat / Etc. Year: _____
☐ Make: _____
☐ Model: _____

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

Utilities & Bills to Be Paid: ***PLEASE HAVE YOUR BILLS SENT DIRECTLY TO TSUNAMI***

(attach copies of latest bills and/or account statements - SSA requires us to have a physical copy in our files)

Name of Vendor & Account #

(1) _____
(2) _____
(3) _____

Name of Vendor & Account #

(4) _____
(5) _____
(6) _____

After Rent, Utilities & Bills are paid, Client would like their Food & PNI funds to be:

☐ Divided into 2 equal payments and distributed on the **1st and 15th** of each month ~ OR ~

☐ Divided into 4 equal payments and distributed n the **1st, 8th, 15th and 22nd** of each month ~ OR ~

☐ Divided into 5 equal payments and distributed to me weekly on: ☐ Mon ☐ Wed ☐ Fri



☐ I would like to receive my disbursements via paper check. I understand Tsunami has no control over mailing delivery times and will not be responsible for non-delivered mail.



☐ I would like to receive my disbursements via TrueLink Prepaid Debit Card. I understand this is a third-party supplier and is not managed by Tsunami Enterprises. ***TrueLink Agreement must be signed & returned.***



☐ I would like to receive my disbursements via Direct Deposit into my personal bank account. I understand that Tsunami Enterprises has no control over the timing of financial institutions posting funds. ***Direct Deposit Agreement must be signed & returned.***

Is Client currently working? ☐ Yes ☐ No

Employer: _____

City: _____ State: _____ Zip: _____

Date of Hire: ___/___/___ Est Monthly: $ _____

Pay Frequency: ☐ Weekly ☐ 2x month ☐ Monthly

Has the Client worked in the past 2 Years? ☐ Yes ☐ No

Employer: _____

City: _____ State: _____ Zip: _____

Date of Hire: ___/___/___ Est Monthly: $ _____

Pay Frequency: ☐ Weekly ☐ 2x month ☐ Monthly

All wages must be promptly reported to Tsunami & copies of all paystubs must be submitted to Tsunami for reporting to SSA.

Failure to do so will cause Client's benefits to be suspended & Tsunami to release client due to non-compliance.

Does Client have a valid current will?

☐ Yes Executor Name: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

Work Phone #: (____) _____ Date signed: ___/___/___

☐ No Next of Kin: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

Home Phone #: (____) _____ Relationship: _____

In the unfortunate event of the client's passing, Tsunami is required by Social Security to return unspent funds to Social Security UNLESS there is a valid will or legal next of kin.

Does Client own a pre-need burial plan? ☐ Yes ☐ No

Does Client own a headstone / burial plot / etc.? ☐ Yes ☐ No

Mortuary Name: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

Work Phone #: (____) _____ Cell Phone #: (____) _____

Does Client have a Burial Trust Account? ☐ Yes ☐ No

Bank Name: _____

Work Phone #: (____) _____ Acct # _____

ADDITIONAL INFORMATION

Has Client ever been convicted of a crime *(other than a simple traffic offense)*? ☐ Yes ☐ No

Is Client currently incarcerated? ☐ Yes ☐ No

For **CURRENT** convictions, please provide the following:

Jail / Prison Name: _____

City: _____ State: _____ Zip: _____

Date In: ___/___/___ Date Out: ___/___/___

Charges: ☐ Misdemeanor(s) ☐ Felony

Release paperwork MUST be submitted to Tsunami ASAP after release in order to have your benefits re-instated.

Parole / Probation Officer Name: _____

Work Phone #: (___) _____ Alt Phone #: (___) _____

For **PRIOR** convictions, please provide the following:

Offense #1: _____ Charge: ☐ Misdemeanor ☐ Felony

Which Court? _____

Arrest Date: ___/___/___

Disposition: ☐ Not Guilty ☐ Guilty / No Contest ☐ Other: _____

Did Client serve any time in jail other than while awaiting trial? ☐ Yes ☐ No

Years: _____ # Months: _____

Date In: ___/___/___ Date Out: ___/___/___

Does Client owe any fines or restitution from this conviction? ☐ Yes ☐ No

If so, how much? $ _____ *Provide court order showing restitution amount & applicable case #.*

Provide a legible copy of as many of the following as possible:

☐ Drivers License / State ID Card # _____ State: _____

☐ SSA Card

☐ MediCare Card # _____ Issued: ___/___/___

☐ MediCal Card # _____ Issued: ___/___/___

NOTIFY TSUNAMI WITHIN 3 DAYS OF ANY OF THE FOLLOWING:

* The Client moves from the current living situation
* Someone permanently moves into or out of Client's residence
* The Client enters a locked facility (such as jail or prison)
* The Client changes their phone number
* The Client enters or leaves a hospital or skilled nursing facility
* The Client leaves the state of California for more than 30 days
* The amount of child support or alimony changes
* The Client opens or closes a personal bank account
* The Client purchases a burial plot or headstone
* The Client purchases life insurance on themselves or another
* The Client buys or sells any auto, RV, motorcycle, boat, etc.
* The Client buys or sells any real estate or dwelling
* The Client receives money from an additional source
* The Client starts or stops working
* The Client wins money from gambling and/or lottery
* The Client inherits or is given money

REMARKS and/or ADDITIONAL INFORMATION

PLEASE REMEMBER TO INCLUDE COMPLETED & SIGNED STATEMENT OF CLAIMANT (S) AND PHYSICANS' STATEMENT FORMS WITH THIS PACKET.

WE CAN NOT SUBMIT THE APPLICATION TO SOCIAL SECURITY IF THESE FORMS ARE MISSING.

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 **TSUNAMI ENTERPRISES** 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 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 (9-94)
Destroy prior editions
*U.S. Government Printing Office: 1994 - 300-946/00180

Tsunami Enterprises

PO Box 6189, Santa Rosa, CA 95406
P: 707.462.2546 or 707.564.6966 | F: 707.462.6235
www.tsunami-enterprises.org

Date Recv'd	Recv'd By

Agreement for Services

Name: _____

SSN #: | X | X | X | - | X | X | - | | | | |

I have discussed my needs with Tsunami Enterprises and I agree to have Tsunami Enterprises serve as my Representative Payee for Social Security and/or SSI payments.

I will:

* Be clean & sober when conducting business with Tsunami Enterprises
* Treat staff with courtesy and respect at all times
* Receive money for spending as agreed
* Provide receipts when needed and/or requested

I understand that if I fail to comply with these rules, Tsunami Enterprises may refuse to continue to serve as my Representative Payee. I also understand and agree that Tsunami Enterprises assumes no responsibility or liability to me or others in making disbursements based on information or instructions I have provided and/or within the Social Security Administration Guidelines and/or other laws/regulatory requirements.

Tsunami Enterprises will:

* Treat me with courtesy and respect at all times
* Use funds received on my behalf to meet my current and immediate needs
* Report to SSA any events or changes that might affect my benefits
* Account to SSA on how my funds have been saved and/or spent
* Save any unspent funds for my future needs
* Return to SSA any funds that have been saved or to which I am not entitled

Signature of Client _____ Date _____

Signature of Beneficiary or Legal Guardian _____ Relationship (if not Client) _____

Signature of Tsunami Payee _____ Date _____

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Date Recv'd	Recv'd By

Authorization to Release Information

Name: _____

SSN #: X X X - X X - _____

DOB: _____ / _____ / _____

I hereby give my consent to **Tsunami Enterprises, Inc.** 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 **Tsunami Enterprises, Inc.** 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(s)
- ☐ Wages / Employment
- ☐ Address
- ☐ Living Arrangement
- ☐ Account Ledger / Statement
- ☐ Burial Trust
- ☐ Utility Bills / Personal Bills
- ☐ Current Monthly SSA / SSI
- ☐ MediCal / MediCare
- ☐ Social History
- ☐ O.H.S. Plan / Appointments
- ☐ Medical / Dental / Vision
- ☐ Hospital / Clinic / Outpatient
- ☐ Other _____
- ☐ Other _____

By signing below I declare (1) that 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, (2) 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, (3) I understand and affirm that Tsunami Enterprises, Inc. is not responsible if a person authorized to obtain information regarding my account does so with false pretenses and (4) I understand and affirm Tsunami Enterprises, Inc. is not responsible for any effect to my benefits caused by releasing the requested information.

Signature of Client _____ Date _____

Signature of Beneficiary or Legal Guardian _____ Relationship (if not Client) _____

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Date Recv'd	Recv'd By

Client Budget Worksheet

Name: _____

SSN #: X X X - X X - _ _ _ _

ESTIMATED MONTHLY INCOME

SSI BENEFITS	(ssn #)	Amount: $	-
SSA / SSDI BENEFITS	(ssn #)	Amount: $	-
VA BENEFITS	(va #)	Amount: $	-
RAILROAD BENEFITS	(company)	Amount: $	-
PENSION	(company)	Amount: $	-
RENTAL INCOME	(property)	Amount: $	-
CHILD SUPPORT	(names)	Amount: $	-
OTHER	(describe)	Amount: $	-
	TOTAL ESTIMATED MONTHLY INCOME:	$	-

ESTIMATED MONTHLY EXPENSES

RENT / HOUSING	(landlord)	Amount: $	-
BD & CARE / SOC	(facility)	Amount: $	-
PAYEE FEE	(vendor)	Amount: $	-
FOOD & PNI	(vendor)	Amount: $	-
WATER / SEWER / ETC	(vendor)	Amount: $	-
ELECTRICTY / GAS	(vendor)	Amount: $	-
CABLE / INTERNET	(vendor)	Amount: $	-
PHONE / WI-FI	(vendor)	Amount: $	-
INSURANCE	(vendor)	Amount: $	-
RX COPAY	(vendor)	Amount: $	-
STORAGE	(vendor)	Amount: $	-
AUTO EXPENSES	(vendor)	Amount: $	-
OTHER	(vendor)	Amount: $	-
OTHER	(vendor)	Amount: $	-
	TOTAL ESTIMATED MONTHLY EXPENSES:	$	-

BUDGET VARIANCE $ -

COPIES OF ALL BILLS MUST BE SENT TO TSUNAMI FOR PAYMENT. THE BILLING ADDRESS ON ALL BILLS SHOULD BE CHANGED TO PO BOX 6189, SANTA ROSA, CA 95406.

Tsunami Enterprises

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Date Recv'd	Recv'd By

Direct Deposit Agreement Form - *OPTIONAL*

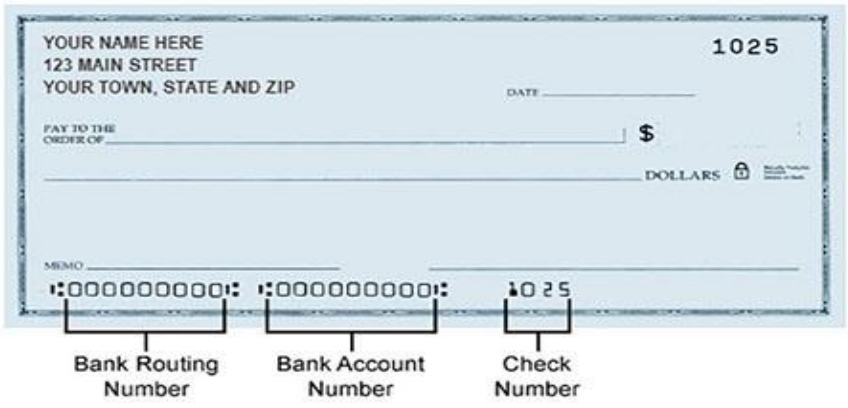
Name: _____

SSN #: | X | X | X | - | X | X | - | | | | |

AUTHORIZATION AGREEMENT

I hereby authorize Tsunami Enterprises, Inc. to initiate automatic deposits to my account at the financial institution named below. I also authorize Tsunami Enterprises, Inc. to make withdrawals from this account in the event that a credit entry is made in error. Further, I agree not to hold Tsunami Enterprises, Inc. responsible for any delay or loss of funds due to incorrect or incomplete information supplied by me or by my financial institution or due to an error on the part of my financial institution in depositing funds to my account. This agreement will remain in effect until Tsunami Enterprises, Inc. receives a written notice of cancellation from me or my financial institution, or until I submit a new direct deposit form to Tsunami Enterprises.

ACCOUNT INFORMATION



Name of Financial Institution:
Routing Number:
Account Number:

☐ Checking Account ☐ Savings Account

~~ Attach a voided check & return this form to Tsunami Enterprises ~~

SIGNATURE

Print Full Name (Primary) _____

Authorized Signature (Primary) _____ Date _____

Print Full Name (Joint) _____

Authorized Signature (Joint) _____ Date _____

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Date Recv'd	Recv'd By

Client TrueLink Card Agreement - *OPTIONAL*

Name: _____

SSN #: | X | X | X | - | X | X | - | | | | |

AUTHORIZATION AGREEMENT

True Link

The True Link Card is a reloadable Visa card, which enables TSUNAMI ENTERPRISES to make disbursements safely, quickly, and reliably. The card also allows beneficiaries and their representatives the freedom to purchase things that enhance their quality of life. Please read the rules below used to govern the card.

We require you to sign this Client True Link Agreement in order to use the card.

TERMS OF USE

- The card is not transferable, and cannot be resold or transferred for cash.
- Lost / stolen cards will be replaced without charge one time per quarter (3 months).
- Additional replacement cards will incur a $5 fee & will be charged against your card balance.
- Cards will be shipped directly by TrueLink to a physical address only, not a PO Box.
- If the card is returned due to incorrect address, funds will be frozen until Tsunami gets a valid address.
- If the funding day(s) falls on a weekend or holiday, the funds will post on the business day prior.
- For inquiries about card balance & transactions, please contact True Link directly at 1-800-299-7646.

SIGNATURE

By signing below, I acknowledge I wish to utilize the TrueLink card to receive funds from Tsunami Enterprises. I agree to the rules set out in this Client True Link Card Agreement. I understand that if these rules are not followed or if the True Link Card is misused in any way, my card privileges will be terminated.

_____ _____

Signature Date

Tsunami Enterprises

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Date Recv'd	Recv'd By

What Happens Next?

1) At the time of intake, the Tsunami representative will review the packet and request any missing documentation. We will then submit our application to become your Representative Payee to Social Security. We do not control the time it takes Social Security to process applications. Usually, it takes between 2 and 6 months between submission and receipt of funds.
2) At the time of award, you will be told who your Rep Payee is, and you will be provided with their contact information. Your Rep Payee is the person you will speak with regarding your account. You must notify them as soon as possible in the event of any changes to your living arrangements, your additional income, or your contact information
3) Your Rep Payee has a voicemail box and email for you to contact them. They will return your call and/or email as soon as possible during regular business hours. It is important to leave full details on your voice message. Always leave your first and last name, the phone number where you can be reached, and detailed reason for your call. **PLEASE LEAVE ONLY ONE MESSAGE PER DAY AND ALLOW THE REP PAYEE 24 HOURS TO RETURN YOUR CALL.** Leaving multiple messages will only delay your returned call.
4) The office lobby is open from 9:00am to 4:00pm Monday through Friday, and is closed for lunch from 12:00pm to 1:00pm. Our office is closed on all federal and banking holidays.
5) If possible, your budget is established at the time of the award. If we are unable to establish a budget at that time, you and/or your Case Manager will need to contact your Rep Payee before any funds can be released. If Tsunami Enterprises is unable to contact you and/or your Case Manager, we will not release funds.
6) You will need to provide a copy of your rental agreement and bills that you would like Tsunami to pay before payment can be made. All utility bills should have the billing address changed to the Santa Rosa Tsunami office. Any rent notices received by the Client must be forwarded to Tsunami within 10 days of receipt.
7) 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 discussed with your Rep Payee at least 10 days before the last business day of the month
8) 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. Please give your Rep Payee 24-48 hours to process your request. Immediate requests will only be allowed for emergency reasons, only once per month, and at the discretion of your Rep Payee.
9) Rent and vendor checks will be mailed directly to entity to whom the check is made payable. These checks will not be released to the Client except under extenuating circumstances and after discussion with your Rep Payee. Please allow 10 business days for the delivery of mailed checks.
10) If you do not receive your check after 10 business days, it is your responsibility to immediately report it to Tsunami as lost. We will then issue a Stop Payment and re-issue the check if requested. A $20.00 fee will be charged to the client for every Stop Payment request.
11) Tsunami 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.

~ Client's Initials ~

~ Rep Payee's Initials ~

Medical Source Opinion of Patient's Capability to Manage Benefits

	In replying, use this address: SOCIAL SECURITY ADMINISTRATION
	TELEPHONE NUMBER (Including Area Code)
	DATE
	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 SOCIAL SECURITY NUMBER	PATIENT'S DATE OF BIRTH

PATIENT'S ADDRESS (Number and Street, City, State, and ZIP Code)

YOUR HELP IS NEEDED

The patient shown above has filed for or is receiving Social Security or Supplemental Security Income benefits. 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 manage the Social Security Administration (SSA) benefits on his or her behalf.

Please Note: This determination affects how benefits are paid and has no bearing on disability determinations. Unfortunately, SSA cannot compensate you for the time it takes to provide this information. Thank you for your help.

WHAT IS A REPRESENTATIVE PAYEE

A representative payee is someone who manages the patient's SSA benefits to make sure the patient's basic 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 managing their SSA benefits or directing others to manage them to meet their basic needs, so we select a representative payee to receive their benefits on their behalf. Examples of impairments that may cause incapability are dementia, brain damage or chronic schizophrenia. However, a person's need for some assistance with financial tasks such as bill paying, etc., does not necessarily mean he or she cannot make decisions concerning basic needs and is incapable of managing his or her own benefits. If the individual is able to direct the management of his or her own benefits, then we will consider the individual capable.

PLEASE COMPLETE THE INFORMATION ON THE REVERSE OF THIS FORM

PATIENT'S NAME

PATIENT'S SOCIAL SECURITY NUMBER	PATIENT'S DATE OF BIRTH

PATIENT'S ADDRESS (Number and Street, City, State, and ZIP Code)

1. Date you first saw the patient _____

2. Date you last saw the patient _____

3. How many times have you seen this patient? _____

4. Are you able to assess the patient's ability to manage or direct the management of funds? ☐ Yes ☐ No

   If no, please skip the remaining questions and sign and date the form.

5. What is the basis for your assessment (e.g. observation, medical records, diagnostic tests, patient's self-report, family member's report)?

Note: Please keep in mind in responding to the following questions that the actual performance of the patient, when known, is usually the best indicator of the patient's abilities.

6. Does the patient:

- Have a general understanding of his or her finances (i.e., income, assets, expenses)? ☐ Yes ☐ No ☐ Unknown
- Have sufficient ability to handle a checking/savings account? ☐ Yes ☐ No ☐ Unknown
- Have sufficient ability to pay bills in a timely manner? ☐ Yes ☐ No ☐ Unknown

7. Can the patient successfully manage or direct the management of funds to meet basic needs (e.g. food, clothing, shelter)?

☐ Yes
If "Yes," please provide a brief summary of the findings that led to this conclusion, and complete question 8. Please also sign and date the form.

☐ No
If "No," please provide a brief summary of the findings that led to this conclusion, and complete question 8. Please also sign and date the form.

☐ Unsure
"Unsure," please explain and sign and date the form.

8. Do you expect the patient to be able to manage or direct the management of his or her benefits in the future (e.g. the patient is temporarily unconscious)?

☐ Yes ☐ No

Please explain your answer.

NAME OF MEDICAL SOURCE (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 statement about a material fact in this information, or causes someone else to do so, commits a crime and may be subject to a fine or imprisonment.

SIGNATURE OF MEDICAL SOURCE	DATE

Privacy Act Statement
Collection and Use of Personal Information

Sections 205, 807, and 1631(a) of the Social Security Act, as amended, allow us to collect this information. Furnishing us this information is voluntary. However, failing to provide all or part of the information may prevent us from making a determination regarding the beneficiary's capability or inability to handle his or her own benefits.

We will use the information to determine the beneficiary's need for a representative payee. We may also share your information for the following purposes, called routine uses:

- To Federal, State, or local agencies for administering cash or non-cash income maintenance or health maintenance programs; and

- To contractors and other Federal agencies, as necessary, for the purpose of assisting the Social Security Administration in the efficient administration of its programs.

In addition, we may share this information in accordance with the Privacy Act and other Federal laws. For example, where authorized, we may use and disclose this information in computer matching programs, in which our records are compared with other records to establish or verify a person's eligibility for Federal benefit programs and for repayment of incorrect or delinquent debts under these programs.

A list of additional routine uses is available in our Privacy Act System of Records Notices (SORN) 60-0089, entitled Claims Folders Systems, as published in the Federal Register (FR) on April 1, 2003, at 68 FR 15784, and 60-0222, entitled Master Representative Payee File, as published in the FR on April 22, 2013, at 78 FR 23811. Additional information, and a full listing of all our SORNs, is available on our website at www.ssa.gov/privacy.

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 20 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).** *You may send comments on our time estimate above to: SSA, 6401 Security Blvd, Baltimore, MD 21235-6401.* ***Send only comments relating to our time estimate to this address, not the completed form.***

STATEMENT OF CLAIMANT OR OTHER PERSON

Name of Wage Earner, Self-employed Person, or SSI Claimant	Social Security Number
Name of Person Making Statement *(If other than above wage earner, self-employed person, or SSI claimant)*	Relationship to Wage Earner, Self-Employed Person, or SSI Claimant

Understanding that this statement is for the use of the Social Security Administration, I hereby certify that -

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 statement about a material fact in this information, or causes someone else to do so, commits a crime and may be subject to a fine or imprisonment.

SIGNATURE OF PERSON MAKING STATEMENT

Signature *(First name, middle initial, last name) (Write in ink)*	Date *(Month, day, year)*
	Telephone Number *(Include Area Code)*

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

City and State	ZIP Code

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 individual 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)*

Privacy Act Statement

Collection and Use of Personal Information

Section 205(a) of the Social Security Act, as amended, allows us to collect this information. Furnishing us this information is voluntary. However, failing to provide all or part of the information may prevent an accurate and timely decision on any claim filed.

We will use this information you provide to determine benefits eligibility. We may also share the information for the following purposes, called routine uses:

- To third party contacts (including private collection under contract with us), for the purpose of their assisting us in recovering overpayments; and
- To contractors and other Federal agencies, as necessary, for the purpose of assisting us in the efficient administration of our programs. We will disclose information under this routine use only in situations in which we may enter into a contractual or similar agreement to obtain assistance in accomplishing an SSA function relating to this system of records.

In addition, we may share this information in accordance with the Privacy Act and other Federal laws. For example, where authorized, we may use and disclose this information in computer matching programs, in which our records are compared with other records to establish or verify a person's eligibility for Federal benefit programs and for repayment of incorrect or delinquent debts under these programs.

A list of additional routine uses is available in our Privacy Act System of Records Notices (SORN) 60-0089, entitled Claims Folders System, as published in the Federal Register (FR) on October 31, 2019, at 84 FR 58422; 60-0090, Master Beneficiary Record, as published in the FR on January 11, 2006, at 71 FR 1826; 60-0103, Supplemental Security Income Record and Special Veterans Benefits, as published in the FR on January 11, 2006, at 71 FR 1830; and 60-0320, entitled Electronic Disability Claim File, as published in the FR on June 4, 2020, at 85 FR 34477. Additional information, and a full listing of all of our SORNs, is available on our website at www.ssa.gov/privacy.

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 (OMB) control number. We estimate that it will take about 15 minutes to read the instructions, gather the facts, and answer the questions. ***Send only comments regarding this burden estimate or any other aspect of this collection, including suggestions for reducing this burden to:*** *SSA, 6401 Security Blvd, Baltimore, MD 21235-6401.*