Client Set-up Checklist

#	Set-Up Forms	Information
1	Client Set-up Form	Required for all new clients.
2	Addition to Client Set-up Form	Required for all new clients.
3	Informed Consent for Release of Information	Required for all new clients.
4	Private Pay Service Agreement	Only required for Private Pay clients.
5	Advance Notification of Representative Payment (Form SSA-4164)	Required for all new clients.
6	Request to be Selected as Payee (Form SSA-11-BK)	Required for all new clients.
7	Physician's/Medical Officer's Statement of Patient's Capability to Manage Benefits (Form SSA-787)	Required for clients who do not have a current payee.

IMPORTANT:
Not submitting all documents or submitting incomplete and/or unsigned documents will delay the application process.

MCFI
MILWAUKEE CENTER FOR INDEPENDENCE

MCFI Representative Payee Services

Client Set-up Form

Client Information

Client Name: _____

Street Address: _____ Apt/Room No.: _____

City: _____ State: _____ ZIP: _____

Phone Number: (_____) _____-_____ Date of Birth: _____/_____/_____

Social Security Number: _____-_____-_____ Gender: _____

Client Income Source(s): _____ Amount: $ _____

_____ Amount: $ _____

_____ Amount: $ _____

Race: ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American
☐ Native Hawaiian or Other Pacific Islander ☐ White (includes Middle Eastern and North African)

Are you Hispanic or Latino (a person of Spanish culture or origin, regardless of race)?
☐ Yes ☐ No

Guardian Information (if applicable) – Please provide copy of guardianship papers.

Contact Name: _____

Street Address: _____

City: _____ State: _____ ZIP: _____

Phone Number: (_____) _____-_____ Relationship: _____

Additional Information

1. Reason for Referral:
   _____
2. Does client have a current payee? Please provide contact information:
   _____
   _____
3. Any other relevant information:
   _____

Service Information

Service Requested: ☐ Rep Payee ☐ Money Management Referral Date: _____
Representation: ☐ Agency ☐ Private Pay

Agency Name: _____ Phone Number: (_____) _____-_____

Case Manager: _____ Email: _____

Case Manager Signature: _____ Date: _____

MCFI
MILWAUKEE CENTER FOR INDEPENDENCE

MCFI Representative Payee Services

Addition to Client Set-up Form

Service Information

Client must provide a copy of all bills.

Rent

Amount: $_____

Landlord Name and Address:

_____

_____

_____

Pharmacy

Amount: $_____

Account Number:

_____

Name of Pharmacy:

_____

WE Energies

Amount: $_____

Account Number:

_____

Name on the Account:

_____

Cell Phone Bill

Amount: $_____

Carrier (Metro, Cricket, Etc.):

_____

Phone Number:

_____

AT&T

Amount: $_____

Account Number:

_____

Name on the Account:

_____

OTHER

Amount: $_____

Name: _____

Account Number:

_____

Spectrum

Amount: $_____

Account Number:

_____

OTHER

Amount: $_____

Name: _____

Account Number:

_____

MCFI
MILWAUKEE CENTER FOR INDEPENDENCE

MCFI Representative Payee Services

Addition to Client Set-up Form

Allowance Schedule and Direct Deposit Information

Current Allowance Schedule:

_____

If you would like direct deposit, please provide:

_____
Routing Number

_____
Account Number

Allowances that are sent by direct deposit can take up to 24 hours to show up in your account.

If direct deposit information is NOT provided, all payments will be mailed out via check. Weekly allowances are sent on Mondays unless it is a holiday, then it is the next business day.

Acknowledgement and Consent

By signing below, I am verifying that these are the ONLY accounts that my payee will be making payments to on my behalf. I understand that any changes or additions to these accounts will need to be communicated immediately to my Rep Payee.

A copy of all bills MUST be provided to your Rep Payee.

Representative Payee Client Signature: _____Date: _____

Phone: 414-937-2175 • Fax: 414-755-7053

MCFI
MILWAUKEE CENTER FOR INDEPENDENCE

MCFI Representative Payee Services

Informed Consent for Release of Information

Date: _____

Release of Information Statement

I, _____ (Client name), date of birth

_____/_____/_____ (Client date of birth), hereby consent to the disclosure of my

☐ Medical information
I understand the information disclosed may include reference to or treatment of physical illness, emotional illness, developmental disabilities, alcohol abuse, drug abuse, and/or HIV.

☐ Financial and account information
I understand the information disclosed may include reference to income and indebtedness.

to the Milwaukee Center for Independence (MCFI), 2020 West Wells Street, Milwaukee, WI 53233, for the purpose of obtaining Representative Payee Services.

Acknowledgement and Consent

This consent shall remain in effect until the date that MCFI stops providing Representative Payee Services to me. I understand that I may revoke this consent at any time by providing written notice to the person or entity providing the information, along with a copy to MCFI at the address above. I understand that I have the right to request copies of the released material and that the confidentiality of my records is protected by law. My refusal to consent will not result in denial or limitation of services.

Information disclosed pursuant to this consent may be re-disclosed by MCFI to the extent necessary in order to provide Representative Payee Services and thereafter will not be covered by federal privacy laws.

Client Signature: _____ Date: _____

Client Name: _____

Client Address: _____

Parent/Guardian Signature*: _____ Date: _____
** When the Client is an adult and a legal guardian's signature is provided, proof of legal guardianship is required for release of information.*
Parent/Guardian Name: _____

Witness Signature: _____ Date: _____

MCFI
MILWAUKEE CENTER FOR INDEPENDENCE

MCFI Representative Payee Services

Private Pay Service Agreement

Date: _____

Client Information

Client Name: _____

Street Address: _____

City: _____ State: _____ ZIP: _____

Phone Number: (_____) _____-_____

Date of Birth: _____/_____/_____

Acknowledgement and Consent

I understand that by requesting Representative Payee services from the Milwaukee Center for Independence (MCFI), I am directly and solely responsible for payment of such services whether or not covered by private insurance or other payment sources and/or I have the ability to pay for services. All MCFI services are payable upon receipt.

Service Type: Representative Payee
Rate: $54.00 or 10% of the monthly payment per month (whichever is less)

Rates may change on a yearly basis as determined by the Social Security Administration.

Client Signature: _____ Date: _____

Guardian Signature: _____ Date: _____

Representative Payee Signature: _____ Date: _____

Phone: 414-937-2175 • Fax: 414-755-7053

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 (5-2005)
Destroy Prior Editions

REQUEST TO BE SELECTED AS PAYEE

PRINT IN INK:

FOR SSA USE ONLY							
Name or Bene. Sym.	Program	Date of Birth	Type	Gdn.	Cus.	Inst.	Nam.

FOR SSA USE ONLY

DISTRICT OFFICE CODE

STATE AND COUNTY CODE

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, 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/conservator? ☐ YES ☐ NO

IF YES, enter the legal guardian/conservator'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

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

10. Does the claimant owe you/your organization any money now or will he/she owe you money in the future? ☐ YES ☐ NO

If YES, enter the amount he/she owes you/your organization, the date(s) was/will be incurred and describe why the debt was/will be incurred.

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

11. (a) Enter the name of the institution _____

(b) Enter the EIN of the institution _____

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. 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?

15. (a) Main source of your income

- ☐ Employed (answer (b) below)
- ☐ Self-employed (Type of Business _____)
- ☐ Social Security benefits (Claim Number _____)
- ☐ Pension (describe _____)
- ☐ Supplemental Security Income payments (Claim Number _____)
- ☐ Temporary Assistance For Needy Families (TANF _____)
- ☐ Other State or Public Assistance (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.)

16. Do you give Social Security permision to conduct a criminal background check on you? ☐ YES ☐ NO

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? ☐ YES ☐ 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)

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 *(Month, day, year)*
Signature *(First name, middle initial, last name) (Write in ink)* Rebecca L. Jackson	Telephone number(s) at which you may be contacted during the day

Print Your Name & Title *(if a representative or employee of an institution/organization)*
Rebecca L. Jackson VP Home & Community Based Services

Mailing Address *(Number and street, Apt. No., P.O. Box, or Rural Route)*
2020 W. Wells Street

City and State	Zip Code	Name of County
Milwaukee, WI	53233	Milwaukee

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

City and State	Zip Code	Name of County

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 *(Number and street, City, State and ZIP Code)*	ADDRESS *(Number and street, City, State and ZIP Code)*

SOCIAL SECURITY
Information for Representative Payees Who Recieve Social Security Benefits

YOU MUST NOTIFY THE SOCIAL SECURITY ADMINISTRATION PROMPTLY IF ANY OF THE FOLLOWING EVENTS OCCUR AND PROMPTLY RETURN ANY PAYMENT TO WHICH THE CLAIMANT IS NOT ENTITLED:

- the claimant DIES (Social Security entitlement ends the month before the month the claimant dies);
- the claimant MARRIES, if the claimant is entitled to child's, widow's, mother's, father's, widower's or parent's benefits, or to wife's or husband's benefits as divorced wife/husband, or to special age 72 payments;
- the claimant's marriage ends in DIVORCE or ANNULMENT, if the claimant is entitled to wife's, husband's or special age 72 payments;
- the claimant's SCHOOL ATTENDANCE CHANGES if the claimant is age 18 or over and entitled to child's benefits as a full time student
- the claimant is entitled as a stepchild and the parents DIVORCE (benefits terminate the month after the month the divorce becomes final);
- the claimant is under FULL RETIREMENT AGE (FRA) and WORKS for more than the annual limit (as determined each year) or more than the allowable time (for work outside the United States);
- the claimant receives a GOVERNMENT PENSION or ANNUITY or the amount of the annuity changes, if the claimant is entitled to husband's, widower's, or divorced spouse's benefit's;
- the claimant leaves your custody or care or otherwise CHANGES ADDRESS;
- the claimant NO LONGER HAS A CHILD IN CARE, if he/she is entitled to benefits because of caring for a child under age 16 or who is disabled;
- the claimant is confined to jail, prison, penal institution or correctional facility;
- the claimant is confined to a public institution by court order in connection WITH A CRIME.
- the claimant has an UNSATISFIED FELONY WARRANT (or in jurisdictions that do not define crimes as felonies, a crime punishable by death or imprisonment exceeding 1 year) issue for his/her arrest;
- the claimant is violating a condition of probation or parole under State or Federal law.

IF THE CLAIMANT IS RECEIVING DISABILITY BENEFITS, YOU MUST ALSO REPORT IF:

- the claimant's MEDICAL CONDITION IMPROVES;
- the claimant STARTS WORKING;
- the claimant applies for or receives WORKER'S COMPENSATION BENEFITS, Black Lung Benefits from the Department of Labor, or a public disability benefit;
- the claimant is DISCHARGED FROM THE HOSPITAL (if now hospitalized).

IF THE CLAIMAINT IS RECEIVING SPECIAL AGE 72 PAYMENTS, YOU MUST ALSO REPORT IF:

- the claimant or spouse becomes ELIGIBLE FOR PERIODIC GOVERNMENTAL PAYMENTS, whether from the U. S. Federal government or from any State or local government;
- the claimant or spouse receives SUPPLEMENTAL SECURITY INCOME or PUBLIC ASSISTANCE CASH BENEFITS;
- the claimant or spouse MOVES outside the United States (the 50 States, the District of Columbia and the Northern Marian Islands).

In addition to these events about the claimant, you must also notify us if:

- YOU change your address;
- YOU are convicted of a felony or any offense under State or Federal law which results in imprisonment for more than 1 year;
- YOU have a UNSATISFIED FELONY WARRANT (or in jurisdictions that do not define crimes as felonies, a crime punishable by death or imprisonment exceeding 1 year) issued for your arrest.

BENEFITS MAY STOP IF ANY OF THE ABOVE EVENTS OCCUR. You should read the informational booklet we will send you to see how these events affect benefits. You may make your reports by telephone, mail, or in person.

REMEMBER:

- **payments must be used for the claimant's current needs or saved if not currently needed;**
- **you may be held liable for repayment of any payments not used for the claimant's needs or of any over payment that occured due to your fault;**
- **you must account for benefits when so asked by the Social Security Administration. You will keep records of how benefits were spent so you can provide us with correct accounting;**
- **to tell us as soon as you know you will no longer be able to act as representative payee or the claimant no longer needs a payee.**

Keep in mind that benefits may be deposited directly into an account set up for the claimant with you as payee. As soon as you set up such an account, contact us for more information about receiving the claimant's payments using direct deposit.

A REMINDER TO PAYEE APPLICANTS

TELEPHONE NUMBER(S) TO CALL IF YOU HAVE A QUESTION OR SOMETHING TO REPORT	BEFORE YOU RECEIVE A DECISION NOTICE	SSA OFFICE	DATE REQUEST RECEIVED
	AFTER YOU RECEIVE A DECISION NOTICE		

RECEIPT FOR YOUR REQUEST

Your request for Social Security benefits on behalf of the individual(s) named below has been received and will be processed as quickly as possible.

You should hear from us within_____ days after you have given us all the information we requested. Some claims may take longer if additional information is needed.

In the meantime, if you change your address, or if there is some other change that may affect the benefits payable, you - or someone for you - should report the change. The changes to be reported are listed on the reverse.

Always give us the claim number of the beneficiary when writing or telephoning about the claim.

If you have any questions about this application, we will be glad to help you.

BENEFICIARY	SOCIAL SECURITY CLAIM NUMBER

Privacy Act Statement - Collection and Use of Personal Information

Sections 205(a), 205(j) and 1631(a)(2) of the Social Security Act, as amended, allow us to collect this information. We will use the information you provide to determine if you are eligible to serve as a representative payee. Furnishing us this information is voluntary. However, failing to provide all or part of the information may prevent us from making a determination to select you as a representative payee. We rarely use the information you supply for any purpose other than what we state above,however, we may use the information for the administration of our programs, including sharing information:

1. To comply with Federal laws requiring the release of information from our records (e.g., to the Government Accountability Office and Department of Veterans Affairs); and,
2. To facilitate statistical research, audit, or investigative activities necessary to ensure the integrity and improvement of our programs (e.g., to the Bureau of the Census and to private entities under contract with us). A list of when we may share your information with others, called routine uses, is available in our Privacy Act System of Records Notices, 90-0090, entitled Master Beneficiary Record; 60-0222, entitled Master Representative Payee File; and 60-0103, entitled Supplemental Security Income Record and Special Veterans Benefits.

Additional information about these and other system of records notices and our programs are available from our Internet website at www.socialsecurity.gov or at your local Social Security office. 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 incorrect payments or delinquent debts under these programs.

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 11 minutes to read the instructions, gather the facts, and answer the questions. ***Send only comments relating to our time estimate above to***: *SSA, 6401 Security Blvd, Baltimore, MD 21235-0001.*

SUPPLEMENTAL SECURITY INCOME
Information for Representative Payees Who Receive Social Security Benefits

YOU MUST NOTIFY THE SOCIAL SECURITY ADMINISTRATION PROMPTLY IF ANY OF THE FOLLOWING EVENTS OCCUR AND PROMPTLY RETURN ANY PAYMENT TO WHICH THE CLAIMANT IS NOT ENTITLED:

- the claimant or any member of the claimant's household DIES (SSI eligibility ends with the month in which the claimant dies);
- the claimant's HOUSEHOLD CHANGES (someone moves in/out of the place where the claimant lives);
- the claimant LEAVES THE U.S. (the 50 states, the District of Columbia, and the Northern Mariana Islands) for 30 consecutive days or more;
- the claimant MOVES or otherwise changes the place where he/she actually lives (including adoption, and whereabouts unknown);
- the claimant is ADMITTED TO A HOSPITAL, skilled nursing facility, nursing home, intermediate care facility, or other institution;
- the INCOME of the claimant or anyone in the claimant's household CHANGES (this includes income paid by an organization or employer, as well as monetary benefits from other sources);
- the RESOURCES of the claimant or anyone in the claimant's household CHANGES (this includes when conserved funds reach over $2,000);
- the claimant or anyone in the claimant's household MARRIES;
- the marriage of the claimant or anyone in the claimant's household ends in DIVORCE or ANNULMENT;
- the claimant SEPARATES from his/her spouse;
- the claimant is confined to jail, prison, penal institution or correctional facility;
- the claimant is confined to a public institution by court order in connection WITH A CRIME;
- the claimant has an UNSATISFIED FELONY WARRANT (or in jurisdictions that do not define crimes as felonies, a crime punishable by death or imprisonment exceeding 1 year) issued for his/her arrest;
- the claimant is violating a condition of probation or parole under State or Federal law.

IF THE CLAIMANT IS RECEIVING PAYMENTS DUE TO DISABILITY OR BLINDNESS, YOU MUST ALSO REPORT IF:

- the claimant's MEDICAL CONDITION IMPROVES;
- the claimant GOES TO WORK;
- the claimant's VISION IMPROVES, if the claimant is entitled due to blindness;

In addition to these events about the claimant, you must also notify us if:

- YOU change your address;
- YOU are convicted of a felony or any offense under State or Federal law which results in imprisonment for more than 1 year;
- YOU have an UNSATISFIED FELONY WARRANT (or in jurisdictions that do not define crimes as felonies, a crime punishable by death or imprisonment exceeding 1 year) issued for your arrest.

PAYMENT MAY STOP IF ANY OF THE ABOVE EVENTS OCCUR. You should read the informational booklet we will send you to see how these events affect benefits. You may make your reports by telephone, mail or in person.

REMEMBER :

- payments must be used for the claimant's current needs or saved if not currently needed. (Savings are considered resources and may affect the claimant's eligibility to payment.);
- you may be held liable for repayment of any payments not used for the claimant's needs or of any overpayment that occurred due to your fault;
- you must account for benefits when so asked by the Social Security Administration. You will keep records of how benefits were spent so you can provide us with a correct accounting;
- to let us know as soon as you know you are unable to continue as representative payee or the claimant no longer needs a payee
- you will be asked to help in periodically redetermining the claimant's continued eligibility or payment. You will need to keep evidence to help us with the redetermination (e.g., evidence of income and living arrangements).
- you may be required to obtain medical treatment for the claimant's disabling condition if he/she is eligible under the childhood disability provision.

Keep in mind that payments may be deposited directly into an account set up for the claimant with you as payee. As soon as you set up such an account, contact us for more information about receiving the claimant's payments using direct deposit.

A REMINDER TO PAYEE APPLICANTS

TELEPHONE NUMBER(S) TO CALL IF YOU HAVE A QUESTION OR SOMETHING TO REPORT	BEFORE YOU RECEIVE A DECISION NOTICE	SSA OFFICE	DATE REQUEST RECEIVED
	AFTER YOU RECEIVE A DECISION NOTICE		

RECEIPT FOR YOUR REQUEST

Your request for SSI payments on behalf of the individual(s) named below has been received and will be processed as quickly as possible.

You should hear from us within_____days after you have given us all the information we requested. Some claims may take longer if additional information is needed.

In the meantime, if you change your address, or if there is some other change that may affect the benefits payable, you - or someone for you - should report the change. The changes to be reported are listed on the reverse.

Always give us the claim number of the beneficiary when writing or telephoning about the claim.

If you have any questions about this application, we will be glad to help you.

BENEFICIARY	SOCIAL SECURITY CLAIM NUMBER

Privacy Act Statement - Collection and Use of Personal Information

Sections 205(a), 205(j) and 1631(a)(2) of the Social Security Act, as amended, allow us to collect this information. We will use the information you provide to determine if you are eligible to serve as a representative payee. Furnishing us this information is voluntary. However, failing to provide all or part of the information may prevent us from making a determination to select you as a representative payee. We rarely use the information you supply for any purpose other than what we state above,however, we may use the information for the administration of our programs, including sharing information:

1. To comply with Federal laws requiring the release of information from our records (e.g., to the Government Accountability Office and Department of Veterans Affairs); and,
2. To facilitate statistical research, audit, or investigative activities necessary to ensure the integrity and improvement of our programs (e.g., to the Bureau of the Census and to private entities under contract with us). A list of when we may share your information with others, called routine uses, is available in our Privacy Act System of Records Notices, 90-0090, entitled Master Beneficiary Record; 60-0222, entitled Master Representative Payee File; and 60-0103, entitled Supplemental Security Income Record and Special Veterans Benefits.

Additional information about these and other system of records notices and our programs are available from our Internet website at www.socialsecurity.gov or at your local Social Security office. 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 incorrect payments or delinquent debts under these programs.

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 11 minutes to read the instructions, gather the facts, and answer the questions. ***Send only comments relating to our time estimate above to**: SSA, 6401 Security Blvd, Baltimore, MD 21235-0001.*

SPECIAL BENEFITS FOR WORLD WAR II VETERANS
Information for Representative Payees Who Receive Special Benefits for WW II Veterans

YOU MUST NOTIFY THE SOCIAL SECURITY ADMINISTRATION PROMPTLY IF ANY OF THE FOLLOWING EVENTS OCCUR AND PROMPTLY RETURN ANY PAYMENT TO WHICH THE CLAIMANT IS NOT ENTITLED:

- the claimant DIES (special veterans entitlement ends the month after the claimant dies);
- the claimant returns to the United States for a calendar month or longer;
- the claimant moves or changes the place where he/she actually lives;
- the claimant receives a pension, annuity or other recurring payment (includes workers' compensation, veterans benefits or disability benefits), or the amount of the annuity changes;
- the claimant is or has been deported or removed from U.S.;
- the claimant has an UNSATISFIED FELONY WARRANT (or in jurisdictions that do not define crimes as felonies, a crime punishable by death or imprisonment exceeding 1 year) issued for his/her arrest;
- the claimant is violating a condition of probation or parole under State or Federal law.

In addition to these events about the claimant, you must also notify us if:

- YOU change your address;
- YOU are convicted of a felony or any offense under State or Federal law which results in imprisonment for more than 1 year;
- YOU have an UNSATISFIED FELONY WARRANT (or in jurisdictions that do not define crimes as felonies, a crime punishable by death or imprisonment exceeding 1 year) issued for your arrest.

BENEFITS MAY STOP IF ANY OF THE ABOVE EVENTS OCCUR. You can make your reports by telephone, mail or in person. You can contact any U.S. Embassy, Consulate, Veterans Affairs Regional Office in the Philippines or any U.S. Social Security Office.

REMEMBER:

- payments must be used for the claimant's current needs or saved if not currently needed;
- you may be held liable for repayment of any payments not used for the claimant's needs or of any overpayment that occurred due to your fault;
- you must account for benefits when so asked by the Social Security Administration. You will keep records of how benefits were spent so you can provide us with a correct accounting;
- to let us know, as soon as you know you are unable to continue as representative payee or the claimant no longer needs a payee.

A REMINDER TO PAYEE APPLICANTS

TELEPHONE NUMBER(S) TO CALL IF YOU HAVE A QUESTION OR SOMETHING TO REPORT	BEFORE YOU RECEIVE A DECISION NOTICE	SSA OFFICE	DATE REQUEST RECEIVED
	AFTER YOU RECEIVE A DECISION NOTICE		

RECEIPT FOR YOUR REQUEST

Your request for Special benefits for WW II Veterans on behalf of the individual(s) named below has been received and will be processed as quickly as possible.

You should hear from us within _____ days after you have given us all the information we requested. Some claims may take longer if additional information is needed.

In the meantime, if you change your address, or if there is some other change that may affect the benefits payable, you - or someone for you - should report the change. The changes to be reported are listed on the reverse.

Always give us the claim number of the beneficiary when writing or telephoning about the claim.

If you have any questions about this application, we will be glad to help you.

BENEFICIARY	SOCIAL SECURITY CLAIM NUMBER

Privacy Act Statement - Collection and Use of Personal Information

Sections 205(a), 205(j) and 1631(a)(2) of the Social Security Act, as amended, allow us to collect this information. We will use the information you provide to determine if you are eligible to serve as a representative payee. Furnishing us this information is voluntary. However, failing to provide all or part of the information may prevent us from making a determination to select you as a representative payee. We rarely use the information you supply for any purpose other than what we state above,however, we may use the information for the administration of our programs, including sharing information:

1. To comply with Federal laws requiring the release of information from our records (e.g., to the Government Accountability Office and Department of Veterans Affairs); and,
2. To facilitate statistical research, audit, or investigative activities necessary to ensure the integrity and improvement of our programs (e.g., to the Bureau of the Census and to private entities under contract with us). A list of when we may share your information with others, called routine uses, is available in our Privacy Act System of Records Notices, 90-0090, entitled Master Beneficiary Record; 60-0222, entitled Master Representative Payee File; and 60-0103, entitled Supplemental Security Income Record and Special Veterans Benefits.

Additional information about these and other system of records notices and our programs are available from our Internet website at www.socialsecurity.gov or at your local Social Security office. 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 incorrect payments or delinquent debts under these programs.

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 11 minutes to read the instructions, gather the facts, and answer the questions. ***Send only comments relating to our time estimate above to**: SSA, 6401 Security Blvd, Baltimore, MD 21235-6401.*

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

SSA CONTACT

IDENTIFYING INFORMATION (SSA Only)
If different from patient

NAME OF WAGE EARNER OR SELF-EMPLOYED PERSON

SOCIAL SECURITY NUMBER
- -

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.

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