Representative Payee Services

To: Applicants/Referring agencies

From: The Advocacy Alliance

RE: Requested Application

The Advocacy Alliance's Representative Payee Service was started in 1982 to make sure that individuals who are unable to manage their own finances were able to get the help they needed to maintain their lifestyles. We have provided reliable and cost-effective Representative Payee Services for over 40 years and currently serve over 5,000 individuals who have mental illness, intellectual disabilities, and older adults. We provide Representative Payee Services in Pennsylvania, New Jersey, and Connecticut. We assist individuals receiving Social Security Administration, Veterans Administration, Black Lung Act, and Railroad Retirement benefits, as well as pensions, annuities, and earned income.

Thank you for your interest in the Representative Payee Program. The requested application is enclosed. The Advocacy Alliance requires the completed application packet with supporting documents returned in order to process.

Please send the application to the contact information below. If you have any questions while completing the application, please do not hesitate to contact.

Sincerely,
Intake Team

Beverly Harris | PH: 570-207-0156 | EM: bh@theadvocacyalliance.org
Sarah Augustine | PH: 570-702-8493 | EM: sa@theadvocacyalliance.org
Main Phone Line: 1-877-315-6855
The Advocacy Alliance, PO Box 1368, Scranton, PA 18501

Representative Payee Application

Please return this form with supporting documents to:
Email: bh@theadvocacyalliance.org & sa@theadvocacyalliance.org
Fax: 570-969-6922
Mail to: The Advocacy Alliance
P.O. Box 1368
Scranton, PA 18501

If you would like a confirmation of receipt, please email application

TAA use only
Fee:_____
A.S.:_____
Program:_____
SS Office: _____
County:_____
Client ID:_____
Date of Processing:_____

PERSONAL INFORMATION: (Required for Processing)			
Client Name:			Soc Sec #:
Address:			Date of Birth:
			Birthplace:
			Mother's Maiden Name:
City:	State:	Zip+4:	County:
Mailing Address:			Gender:
			Marital Status:
City:	State:	Zip+4:	☐ Married ☐ Divorced
Phone #:	Email:		☐ Single ☐ Widowed
Preferred Bank Choice: (choose ONE only - May be assigned by location)			☐ Fidelity ☐ Wells Fargo ☐ PNC Bank
What is your diagnosis/disability:	☐ MH (Mental Health)	☐ ID (Intellectual Disability)	☐ Both
Explain:			

CURRENT PAYEE: (Required for Processing)		
☐ Own Payee	**** A Physician's Statement (SSA-787) required for all applicants****	
☐ Have Payee	Name:	Phone:
	Address:	Relation:
	Why are they no longer willing to be payee?:	
☐ New Claim - Social Security Deemed Necessary		

**** Physician's Statement is included in this packet on pages 6-8. Please submit with original physicians signature.**

EMERGENCY CONTACT/FAMILY: *Next of Kin Required for Processing	
Name:	Relationship:
Address:	Telephone:
	Email:
Name:	Relationship:
Address:	Telephone:
	Email:

GUARDIANSHIP INFORMATION: *Final Decree Must be Submitted for Social Security Processing		
Court appointed legal guardian - If yes, complete the following:	☐ Yes	☐ No
Name of Guardian:	Date of Appointment:	
Address:	Phone Number:	
	Email:	
If the client is a minor, is there a living or adoptive parent?	☐ Yes	☐ No
Name:	Email:	
Address:	Home Phone:	
	Cell Phone:	
Name:	Email:	
Address:	Home Phone:	
	Cell Phone:	

HOUSEHOLD INFORMATION:		
Type of Residence:		
☐ Owns Home	Mortgage Company:	
	Mailing Address:	
	Account #:	Payment Amount:
☐ Apartment/House Rental	Landlord Name:	
	Mailing Address:	
	Rent Amount:	Phone:
☐ Group Home/CLA	Provider Name:	
	Address:	
	Room and Board Amount:	Phone:
☐ Nursing Home	Facility Name:	
	Address:	
	Room and Board Amount:	Phone:
☐ Institution	Facility Name:	
	Address:	
	Room and Board Amount:	Phone:
☐ Other:	Name:	
	Address:	
	Rent Amount:	Phone:

BENEFITS RECEIVING (Check all that apply):			
☐ Social Security Administration (SSDI)	Amount:	Claim Number:	
☐ Supplemental security Income (SSI)	Amount:	Claim Number:	
☐ Railroad Retirement (RR)	Amount:	Claim Number:	
☐ Veterans Administration (VA)	Amount:	Claim Number:	
☐ Black Lung (BL)	Amount:	Claim Number:	
☐ Other:	Amount:	Claim Number:	
☐ Cash Assistance Amount:	☐ Food Stamps Amount:		

HEALTH INSURANCE:		
☐ Medical Assistance	Access #	Effective Date:
☐ Medicare	Part A Claim #:	Effective Date:
	Part B Claim #:	Effective Date:
	Part D Provider:	Claim #:
☐ Other	Name:	Claim #:

REFERAL SOURCE:			
☐ Social Security Administration		Claim Representative:	
☐ Casemanager/Agency		Name of Agency:	
		Address:	Clients BSU#:
		Name of Case Manager:	
		Phone:	Email:
☐ Friend/Relative		Name:	
		Address:	
		Relation:	Phone:
☐ Other		Name:	
		Address:	
		Relation:	Phone:

EMPLOYMENT INFORMATION:				
☐ Not Employed - skip this section				
Employer Name:			Phone:	
Address:				☐ Full Time
				☐ Part Time
How many hours per week:	How many hours per day:		Rate of Pay:	
Employer Name:			Phone:	
Address:				☐ Full Time
				☐ Part Time
How many hours per week:	How many hours per day:		Rate of Pay:	

ASSET INFORMATION:					
☐ Savings Account	Bank Name:	Account #:			Value: $
☐ Checking Account	Bank Name:	Account #:			Value: $
☐ Burial Account	Bank Name:	Account #:			Value: $
☐ Burial Plot	Plot Location:				
☐ Life Insurance	Ins. Company:	Policy #:			Value: $

UTILITY INFORMATION:				
Type:	Company Name:	Company Address:	Account #:	Amount:
Electric				
Heat				
Water				
Refuse				
Sewer				
Fine				
Other				
Other				
Other				

EXPLAIN WHY HAVING A PAYEE IS BEST FOR YOU: *Required for processing
This information will help Social Security process the application as quickly as possible, if additional space is required, please attach a separate sheet

THE ADVOCACY ALLIANCE APPLICATION PROCESS:

1. The Advocacy Alliance may take up to a week to process the **completed** application into our system.
2. We will then submit the application to the Social Security Administration (SSA). Their process may take up to three months to approve payeeship.
3. Once we are approved, we will receive a letter from SSA naming us payee.
4. We will then send the applicant a welcome letter giving further instruction.

OTHER IMPORTANT INFORMATION:

- The purpose of this form is to gather important information about your income and expenses and current money management practices. To ensure timely transition into the program, please complete, sign and return this form through delivery methods listed at the beginning of this application.
- Please make sure your Social Security Number, Name, Current Address, and Date of Birth are completed.
- Ensure all documents are signed to ensure smooth processing.
- You can request a status update by emailing sa@theadvocacyalliance.org.

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

the Advocacy Alliance
A Mental Health Association

Administrative Offices - 846 Jefferson Avenue - P.O. Box 1368 – Scranton, Pa 18501
(T) 570-342-7762 – (TF) 1-877-315-6855 – (F) 570-969-6922 – (E) info@theadvocacyalliance.org - (W) www.theadvocacyalliance.org

Current Representative Payee Request of Termination

Name: _____

Agency/Organization: _____

Address: _____

Phone: _____ Email: _____

This document is to be used in combination with the Advocacy Alliance Representative Payee Application to request a change in representative payee serving the beneficiary named: _____.

I/we am/are no longer suitable to serve as payee for the following reason:

- ☐ Agency Closed
- ☐ Payee Moved out of Area
- ☐ Beneficiary Moved out of Area
- ☐ Other: (explain below)
- ☐ Death of Payee
- ☐ Not able due to Health
- ☐ Misuse of Funds

_____
_____
_____

I understand that this does not automatically terminate my responsibility as Representative Payee. I must wait for confirmation from the Social Security Administration. This request is to be used by The Advocacy Alliance to aid The Social Security Administration application process.

_____ _____
Signature of Current Payee Date

_____ _____
Staff Member/Representative Date

the Advocacy Alliance
A Mental Health Association

Policies and Procedures

I, _____, hereby enter into this Agreement with The Advocacy Alliance for the purpose of managing my finances as Representative Payee for my Social Security and/or SSI benefits. I have read (or had read to me) this Agreement and agree to the following terms and conditions.

1) My payee will disburse my funds following Social Security regulations and our agreed upon budget, paying **basic needs** (shelter, utilities, food, and medical) **first**, and other items (loans/credit cards, telephone, cable, and spending) second.

2) If a need arises, the payee will complete a special request within **five business days**, unless it is an emergency. Emergency is defined as: death, rent deposit, lack of food. Other exceptions will be decided at the discretion of the payee as they arise. Requesting 'extra' money is not an emergency. Requests over $50 require a detailed receipt for Social Security purposes. **Please allow 7-10 business days for US Postal Service delivery**.

3) You, the client have the right to receive a copy of your account register, upon your request, at any time.

4) I understand that The Advocacy Alliance must maintain a safe and courteous office/phone communication. To ensure such an environment, **NO violence, threats of violence, intoxication, drugs, alcohol, or profane language will be permitted** in the office, or during phone communication at any time. I understand that if these standards are violated, The Advocacy Alliance may return my funds to Social Security and refuse to serve further as my Payee.

5) Questions and/or concerns can be directed to the Rep Payee during the hours of 9:30am-4pm Monday through Friday; response time will generally be within 1 business day. Please refrain from calling more than **once** a day.

6) The Representative Payee is responsible for completion and submission of representative payee reports. Other government or social service agencies that need financial information (i.e. Housing, Food Stamps, Medical Assistance), can be directed to this office for income information. All other information will be the responsibility of the beneficiary.

7) I agree to report promptly to my Payee any **changes of address, living arrangements, or earned income** (as required by Social Security regulation). Any changes that are effective on the 1st of the month must be reported by the 25th of the preceding month at the latest!

8) All bills must be sent directly to the Rep Payee. The beneficiary is responsible to make necessary address changes since vendors will not talk to anyone other than the person whose name is on the account. If Mailing address is not changed to our PO Box, TAA is not responsible for late fees.

9) I understand that **any failure to abide** by the terms of this Agreement may result in the termination of the Agreement and the return of my funds to the Social Security Administration. I will then have to **find a new payee for my benefits**.

10) Lastly, I agree to the monthly Payee of 10% of income up to $57 for these services as approved by the Social Security Administration to be disbursed from my account. This fee is subject to change in response to Social Security regulation.

We always strive to provide our services in the best interest of our clients. As Rep Payee, we must follow SSA guidelines and rules and therefore make decisions accordingly.

Please keep for your records.

the Advocacy Alliance
A Mental Health Association

Policy and Procedure Sign-Off Sheet

By signing this, I, _____ confirm that I have received The Advocacy Alliance Payee Services' policies and procedures. I also attest that I have read them completely and thoroughly, understand them to the fullest extent, and agree to abide by the guidelines they establish. If at any time I am unclear about a policy or have a question I will consult my Rep Payee for further guidance.

_____ _____
Client Signature Date

_____ _____
Parent/Guardian/Representative Signature Date

Please return with application.

the Advocacy Alliance
A Mental Health Association

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CONSENT TO RELEASE INFORMATION
TO: The Advocacy Alliance Representative Payee Services

I, _____ authorize

Name: _____

Agency/Organization: _____

Address: _____

Phone: _____ Email: _____

to share all documents and other information about me in his/her/it's possession or knowledge according to the following instructions:

I hereby give my consent to The Advocacy Alliance 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 The Advocacy Alliance Representative Payee Services to obtain and/or exchange information regarding the item(s) below for the purpose of planning for my well-being.

☐ Social Security Number	☐ Medicare/aid	☐ Current Monthly SSA/SSI
☐ Bank Account	☐ Burial Trust	☐ Creditors
☐ Wages/Employment Record	☐ Social History	☐ Utility Bills
☐ Address/Living Arrangement	☐ Medical Records	☐ Other (explain below)

_____
_____
_____

I understand that I may cancel this authorization at any time by notifying the abovenamed individual or entity in writing of my decision. However, my cancellation will not apply to information that the individual or entity and The Advocacy Alliance already shared before they received my written cancellation. This authorization will remain in effect until (1) I give written notice to the abovenamed individual or entity that I am canceling my authorization, or (2) my file with The Advocacy Alliance is closed. A photocopy of this authorization has the same power as the original.

_____ _____
Signature of Claimant or Legal Guardian Date

_____ _____
Advocacy Alliance Staff Member Date

SSA Preference List

Once Social Security receives our application for representative payee services, they need to go through a preference list before they can select us as payee. Social Security's procedure preference list is below. However, if you feel that our agency would be most suitable, you can complete the enclosed "Waiver of Preference" stating the circumstances. We will submit this to Social Security to speed up their selection process. Social Security generally takes 2-4 months to process applications without this preference waiver.

When Social Security determines that the beneficiary needs a representative payee, they select the best payee available from this list of preferred applicants in the order listed below:

1. A spouse, parent or other relative with custody or who shows strong concern;
2. A legal guardian/conservator with custody or who shows strong concern;
3. A friend with custody;
4. A public or nonprofit agency or institution;
5. A Federal or State institution;
6. A statutory guardian;
7. A voluntary conservator;
8. A private, for-profit institution with custody and is licensed under State law;
9. A friend without custody, but who shows strong concern for the beneficiary's well-being, including persons with power of attorney;
10. Anyone not listed above who is qualified and able to act as payee, and who is willing to do so;
11. An organization that charges a fee for its service.

***The Advocacy Alliance is an organization that charges a fee for its service.**

Please complete the next page, labeled "Waiver of Preference" and return with the application.

Waiver of Preference

Date _____

I, _____, waive the order of preference as cited in POMS: GN 00502.105 “Payee Preference Lists”. At this time I do not have anyone else on the preference list that would be suitable to act as my representative payee. I would like to choose The Advocacy Alliance to serve as my fee for service Representative Payee.

Signature _____

Phone Number _____

Did you remember?

1.) Complete the “Representative Payee Application” with completed sections notated as “(Required for Processing)”, including the SSA-787 (if needed);
2.) Have current Representative Payee fill out the “Current Representative Payee Request of Termination”;
3.) Read and understand the “Policies and Procedures” list;
4.) Sign and date the “Policy and Procedure Sign-Off Sheet”;
5.) Sign the “Consent to Release Information”;
6.) Read the SSA Preference List statement;
7.) Sign the “Waiver of Preference” statement

The Advocacy Alliance pledges to provide representative payee services with respect and care. We look forward to serving your financial needs. Please call with any questions or concerns.