BalancedCare

Representative Payee Intake forms

- Intake
- Advanced Notice
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- Debit Card Agreement

BalancedCare Community Services
87 North Clinton Avenue Ste 2
Rochester NY, 14604
Office Phone: (585)360-1854, Fax (888)226-9745

BALANCEDCARE COMMUNITY SERVICES REFERRAL FORM

Date of Referral: _____ Check One: ☐ Self Pay ☐ VA ☐ ICM ☐ Project Link ☐ Act Team ☐ APS ☐ CM ☐ SCM ☐ Project Act

Referral Source: _____

Name _____ DOB____/____/_____

Current Address _____

Date Moved to above Current Address _____

Living Arrangements: Alone ___With Others ___ if with others, pick one: Share Meals___ or Prepare Own___

Home Phone ( ) _____-_____ Cell Phone ( ) _____-_____

Sex: ☐ Male ☐ Female Race _____

Marital Status: ☐ Married ☐ Divorced ☐ Widowed ☐ Single

SS # _____/_____/_____ Claimant SS # (if different) _____/_____/_____

Income Source: _____ Income Source: _____

Amount: $_____ Amount: $_____

Employment Status: _____ Employer _____

Has a SNT / Community Pooled Trust ☐ Yes ☐ No If Yes, Trust is with _____

Currently has a Payee: ☐ Yes ☐ No **If No, please submit Physician's Statement**

PRESENTING PROBLEM: _____

_____

_____

Authorized Contacts:

NAME	ADDRESS	RELATIONSHIP	PHONE #

Place of Birth _____

Mother's Maiden Name _____ Father's Name _____

List other resources such as vehicles, bank accounts, life insurance _____

_____

Outside Case Manager _____ Agency _____ Phone ( ) _____

Case Manager Address _____

Completed form by BCCS Staff _____

(6/2019)

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 **BalancedCare Community Services** to be my Representative payee.

My Right to Appeal

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 also have the right to appeal the decision that I need a payee. If I appeal, I will have the right to review the evidence in the 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 60day 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 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)

SOCIAL SECURITY ADMINISTRATION | TOE 250 | Form Approved OMB No. 0960-0024

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

BalancedCare

Corporate Headquarters:
87 N. Clinton Avenue, Suite 2
Rochester, NY 14607
Phone:585-360-1854
Fax:888-226-9745
Email: BalancedCareInfo@Balanced-Care.org

Representative Payee Agreement

I, _____ ("Client") hereby acknowledge that BalancedCare Community Services will service as my Representative Payee to pay bills on my behalf. BalancedCare Community Services shall receive my funds and be responsible to pay my financial obligations to the extent that there are available funds in my account to do so. Client agrees to pay a monthly fee as determined by the Social Security Administration.

BalancedCare Community Services shall be responsible to disburse funds received on my behalf to meet my current needs such as food, clothing, shelter, utilities, dental and medical care, personal comfort items, and any reasonably foreseeable needs. BalancedCare Community Services, at its sole discretion, may issue client's additional discretionary funds to the extent that all current maintenance needs are fulfilled, and funds remain available to do so. Notwithstanding the foregoing, any additional funds disbursed on the client's behalf will only be done so in the client's best interests.

Client acknowledges that BalancedCare Community Services assumes no responsibility or liability to the Client or others in making disbursements provided the disbursements are made in accordance with the written instructions of the Client.

Client hereby grants BalancedCare Community Services permission to discuss his/her financial matters with the Social Security Administration, and all other individuals and agencies relating to Client's treatment team and support network. This authorization and release provides authority to BalancedCare Community Services to act on the Client's behalf in the payment of the Client's financial needs and obligation(s).

This Agreement shall remain in full force and effect as long as BalancedCare Community Services serves as the Clients Representative Payee.

I HAVE READ, UNDERSTOOD, AND AGREE WITH THE TERMS SPECIFIED IN THIS AGREEMENT

Client: _____ Date: _____

(Signature)

BalancedCare

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True Link Agreement

BalancedCare Community Services has assumed the responsibility of paying bills on the Cardholder's behalf as part of our Representative Payee service. BalancedCare Community Services shall receive Cardholder's funds and is responsible to pay his/her financial obligations in the best interest of Cardholder to the extent that there are available funds to do so.

BalancedCare Community Services shall be responsible to disburse Cardholder's funds to meet his/her current needs such as food, clothing, shelter, utilities, dental and medical care, personal comfort items, and any reasonably foreseeable needs. BalancedCare Community Services may issue additional personal allowance funds to the extent that all current maintenance needs are fulfilled, and funds remain available to do so. BalancedCare Community Services is responsible for properly saving any funds not needed to meet Cardholder's current needs and follow the rules and regulations of the Social Security Administration.

Cards by True Link will be issued to BalancedCare Community Services in the Cardholder's name and as a result, any and all information shall be shared regarding any transactions made with the Card.

Signature of Cardholder:

_____

Date: _____