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 The Ability Center 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)

THE ABILITY CENTER FOR INDEPENDENT LIVING

OFFICIAL APPLICATION

THE ABILITY CENTER

Providing Community based support services for people with disabilities for 31 years

PAYEE SERVICES APPLICATION

CLIENT INFORMATION:

Name:_____

Address:_____

City:_____ State:_____ Zip:_____

Daytime Telephone:_____ Evening Telephone: _____

Date of Birth: _____ Social Security Number: _____

Place of Birth: _____ Mother's Maiden Name: _____

Marital Status: Single_____Married _____

Employment Status: Employed_____Unemployed_____Retired _____

Current Payee (if applicable) _____

Landlord: *(name, address & phone number)* _____

_____

_____

Emergency Contact: *(name, phone number & relationship to you)*

_____

Case Manager: *(name, phone number)* _____

Source(s) of Income: _____

Amount of Monthly Income: _____

Current monthly expenses:

Description	Amount
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Additional Information:

_____

_____

_____

_____

Signature:_____ Date: _____

715 E Idaho Ave ste 3E Las Cruces, NM *Phone: 575-526-5016* *Fax: 575-526-5016*

THE ABILITY CENTER
PAYEE CONTRACT

I, _____ (Consumer Name) hereby appoint THE ABILITY CENTER to be my designated Representative Payee for my social security benefits, SSI, SSD, or other income. **The Ability Center shall receive my benefits or paychecks and be responsible to pay my day-to-day needs to the extent that there are available funds in my account to do so.** The Consumer listed above agrees to pay a FEE of $45.00 per month* to The Ability Center, which will be charged the first day of every month. For this fee, The Center will assist the Consumer in developing a budget, which will be reviewed at a monthly meeting to meet my basic needs regarding food and shelter. In addition, this fee will pay for operating costs of the program such as postage, office equipment, and photocopying.

The Ability Center will focus, as specified in Social Security's Representative Payee Program Handbook, on paying day-to-day needs, and if funds are available after these expenses, recreational and miscellaneous expenses. The Ability Center will provide all designated Representative Payee services as prescribed by law or regulation.

The Consumer mentioned above agrees to the following:

1. Be clean and sober when coming into the office to conduct business Monday through Thursday, from 7 am to 6 pm.
2. Treat staff with courtesy and respect.
3. Understand that day-to-day needs expenses take priority over any other expenses.
4. Sign a receipt when I receive my money.
5. Call or visit at least once a week (especially out-of-town Consumers) for a wellness check.
6. Keep all receipts and return them to The Ability Center for my Consumer Service Record.
7. Understand the budget developed will be strictly followed to aid the Consumer obtain any short-term/long-term goals.
8. Understand that emergency checks will be made out only for life-threatening situations or medical emergencies.
9. Understand that check requests must be made by 1:00 pm to ensure the check is processed the following day (The Maximum amount to withdraw is $100.00 per week, due to reporting purposes with Social Security).
10. Follow the procedures and practices of The Ability Center regarding check disbursement and documentation requirements.
11. Understand The Ability Center will save any unused benefits for future use.
12. Acknowledge that the Ability Center assumes no responsibility or liability to the Consumer or others in making the disbursements provided the disbursements are made in accordance with the written instructions of the Consumer and (or) within the Social Security Administration Guidelines for Representative Payees and other legal or regulatory requirements.
13. Per Social Security Administration, we do not recognize Power of Attorney.

This agreement shall remain in force from the date of execution unless cancelled by the Consumer. Additionally, if a Consumer fails to meet their obligations as mentioned above or practices severe misconduct, The Ability Center reserves the right to provide a Consumer Cancellation Notice to Social Security and the Consumer.

Consumer Signature: _____ Date: _____

Witness: _____ Date: _____

Consumer Fees are regulated by Social Security and are subject to change without any advanced notice.

The Ability Center (TAC) Practices and Procedures Review

_____ initials	**Budget Sheet:** TAC staff has reviewed budget sheet with me.
_____ initials	**HIPAA release:** TAC staff has reviewed HIPAA release with me.
_____ initials	**Rights and Responsibilities:** TAC staff has provided me with a copy of Rights and responsibilities.
_____ initials	**Privacy Practices:** TAC staff has provided me with a copy of their privacy practices.
_____ initials	**Weekly Wellness Check:** TAC asks that Consumers check in with the agency once a week. Out-of-town Consumers are asked to call in and check in with the agency via phone or email.
_____ initials	**No Stop Payments:** TAC, per the Social Security Administration, cannot issue stop payments on Lost Checks.
_____ initials	**Requests:** TAC asks that you allow 24 hours from the time you make a request to the time you need it. Requests need to be made before 1 pm so they may be honored for the next day.
_____ initials	**Request Form:** TAC staff has reviewed the request form with me.
_____ initials	**Mail:** TAC is not responsible for issues that arise with the United State Post Office. It is the Consumer's responsibility they ensure addresses are accurate for mailing. Additionally, Consumers, at their expense, may elect certified mail for their mail.
_____ initials	**Information and Referral:** TAC provides information and referral services to participants of our Payee Program. However, any agreements or contracts made are between the Consumer and parties involved, excluding TAC. We assume no liability other than information and referral services.
_____ initials	**Service Request/Change Form:** TAC staff has reviewed with me the Service Request/Change Form.
_____ initials	**Phone bills:** TAC understands that certain companies offer bills only via text and this makes providing an actual copy difficult. TAC will make payments out to certain providers but not limited to T-mobile. Cricket, Boost Mobile, etc. Payments will be made to the Consumer or company, depending on the preference of the Consumer. Checks will clearly state in the memo line that they are for phone expenses. Consumers are responsible for ensuring payments are accurate and timely. Once TAC has made payments in accord with the Consumer's wishes, TAC assumes no liability regarding late fees and (or) additional charges.
_____ initials	**Bank Accounts:** It is suggested by TAC, at the direction of the Social Security Administration, that all Payees who have separate bank accounts close them. If the Consumer does not want to close the account, this can hurt the Consumer's benefits. If the Consumer does desire to keep the account, TAC needs to receive copies of the monthly statements for the account.

Certification: I certify TAC staff has reviewed with me their practices and procedures. I understand that my initials above mean that I understand and agree to comply with their practices.

Signature:_____ Date:_____

The Ability Center Payee Monthly Spending Plann

Consumer Name _____ Creation Date _____

INCOME

Social Security _____
SSI _____
SSDI _____
Payroll _____
Other _____
Total Income _____

UTILITIES

Paid to: _____ Electric _____
Paid to: _____ Gas _____
Paid to: _____ Water _____
Paid to: _____ Telephone _____
Paid to: _____ Cable _____
Paid to: _____ Cell Phone _____
Utilities Total _____

SHELTER

Paid to: _____ Rent _____
Paid to: _____ Mortage _____
Paid to: _____ Housing _____
Shelter Total _____

FOOD

Paid to: _____ Groceries _____
Food Stamps _____
Food Total _____

PERSONAL ITEMS

Paid to: _____ Clothing _____
Paid to: _____ Hygiene _____
Paid to: _____ Household _____
Allowance ☐ ◯ A check every week for 5 weeks _____
Note _____ Personal Items Total _____

MISCELLANEOUS

Paid to: _____ _____ _____
Paid to: _____ _____ _____
Paid to: _____ _____ _____
Paid to: _____ _____ _____
Paid to: _____ _____ _____
Paid to: _____ _____ _____
Notes
Miscellaneous _____

Payee Representative Monthly Fee
Total Expenses
Net Monthly Income (Total Income minus Expenses)

Consumer Signature: _____ Date: _____

The Ability Center
Recipient's Rights and Responsibilities

CLIENT COPY

Recipient's Rights:

1. Access services that are available regardless of race, religion, color, national origin, gender, age, handicap, marital status, or sexual orientation.
2. Be treated with consideration, respect and full recognition of personal dignity and individuality, including privacy in treatment and care for personal needs.
3. Be fully informed, prior to or at the time of eligibility, of services available through any and all programs.
4. Be fully informed prior to implementation of the individualized Service plan of the specific service components to be provided by the direct service providers and case management, including information of Advanced directives.
5. Participate fully in planning and implementing the Individualized service plan.
6. Communicate in his/her native language with other individuals or provider employees for the purpose of acquiring or providing any type of information, treatment, care, services, etc.
7. Confidentiality of records, communications, and personal information.
8. Review all records pertaining to the recipient.
9. Reasonable continuity of care and service.
10. Know the identity and professional status of individuals providing services to the recipient and be assured that personnel providing care are qualified through education and training experience to carry out the services for which they are responsible.
11. Be fully informed of service provider agency policies and charges for services.
12. Be free from verbal, physical, sexual, psychological, abuse or neglect and to be treated with dignity and compassion always.
13. Voice grievances, suggest changes and communicate confidentially, without consequence, fear of disruption of service, fear of reprisal, or fear of discrimination.
14. Refuse any service components and have the right to be informed of possible consequences, of this action up to including the termination of services.
15. To make grievances known to the case manager, and/or direct service provider in a timely manner.

Client's Responsibilities:

1. Treat service provider employees with dignity, respect and consideration. Service provider employees have the right to be free from verbal, physical, sexual and psychological abuse.
2. Notify the Direct service provider of changes in status including but not limited to Medic- al, personal, and/or living arrangements.
3. Notify the local Income Support Division office of changes in the financial status if necessary.
4. Comply with the Individualized Service Plan.
5. Follow prescribed treatment plans and notify the case manager of changes in treatment and medications.
6. Assist efforts as much as the recipient is able, to attain independence.

I have read or had read to me the Recipients rights and responsibilities and have received information and Advanced Directives. I understand and agree to follow the recipient rights and responsibilities above. I have been informed of possible consequences of non-compliance, including termination of my contract.

Recipient Signature

Date

Witness Signature

Date

HIPAA COMPLIANT AUTHORIZATION FOR THE RELEASE OF CONSUMER INFORMATION PURSUANT TO 45 CFR 164.508

Section 1 Provider and Authorizer: Information I authorize the named provider or agency to release information or covered entities under HIPPA upon request.

Provider (name and address)
The Ability Center for Independent Living
715 E. Idaho Ave. Ste 3E
Las Cruces, NM 88001-4702

Authorizer:_____
SS#_____-_____-_____
DOB:_____

Section II: RECORDS TO BE RELEASED:

Type of Record (check next to category)	Description
___Medical	Admission history, complete hospital chart, diagnoses, discharge summary, medication logs, staff contact/service logs, lab reports, consultation notes and reports. Radiological images, office notes, outpatient records and any records medical or administrative with information relating to me.
___Psychiatric	And other mental health records, including evaluations and assessments, discharge summary.
___Psychotherapy	Psychotherapy Notes
___Education	Records including evaluations and assessments for special education, occupational therapy, speech and language therapy, IEPs, Manifestation Determinations, records of contact with parent/guardian, disciplinary records, and teacher notes.
___Vocational	Vocational Rehabilitation File
___Financial	Notice of benefits balances, wages, bills, claims, collections, etc.
___Other	Any and all evaluations, assessments, and treatment plans

Section III: Representative and Purpose of Disclosure TACIL is authorized to release the designated records above to the following representative for the following purpose.

_____
Name of Representative

_____
Capacity (attorney, service provider, etc.)

_____
Address

_____
City, State, and Zip Code

This protected information is disclosed for the following reasons: _____

_____

Section 4 Rights: I understand the following:

1. This information will be used for the purpose of determining eligibility and service provision by TACIL. I further authorize the persons with knowledge about my records and the issues they describe to discuss my situation with the TACIL representative.
2. I have a right to examine and copy the information disclosed by TACIL.
3. I have a right to revoke this authorization in writing at any time, except to the extent information has been released I reliance upon this authorization.
4. The information released in response to this authorization may be re-disclosed to other parties.
5. Any facsimile, copy, or photocopy of the authorization shall authorize you to release the records requested herein. This authorization shall be in force and effect until one year from date of execution at which time this authorization expires.

_____ _____

Signature of Consumer or Legally Authorized Representative Date

_____

Name and Relationship of Legally Authorized Representative

_____ _____

Witness Signature Date

Date Received (For "Received" stamp)	_____ Expiration Date (one year after execution date)

**********FOR OFFICE USE ONLY**********

The Ability Center
715 E Idaho Ste 3E
Las Cruces, NM 88001

Notice of Privacy Practices – Acknowledgement

We keep a record of all services we provide you. You may ask to see and copy that record. You may also ask to correct that record. We will not disclose your record to others unless you direct us to do so or unless the law authorizes or compels us to do so. You may see your record or get more information about it by contacting The Ability Center HIPPA Privacy Officer at 505-526-5016.

Our Notice of Privacy Practices describes in more detail how your health information may be used and disclosed, and how you can access your information.

By my signature below I acknowledge receipt of the Notice of Privacy Practices.

_____ _____ _____
Consumer or legally authorized individual signature Date Time

_____ _____
Printed Name if signed on behalf of the consumer Relationship (parent, legal guardian, personal representative, etc.)

---------- FOR OFFICE USE ONLY ----------

Identity of Consumer Verified via:

☐ Photo ID ☐ Signature Match Other (specify) _____

Verified by: _____ Title: _____

(Notation, if any, by staff)

This form will be retained in your record.

- We may use and disclose your information to conduct or arrange for services, including:
    - health quality review by your health plan;
    - accounting, legal, risk management, and insurance services;
    - audit functions, including fraud and abuse detection and compliance programs.

Your Health Information Rights

The records we create and store are the property of TAC. The protected health information in them, however, generally belongs to you. You have a right to:

- Receive, read, and ask questions about this Notice;
- Ask us to restrict certain uses and disclosures. You must deliver this request in writing to us. We are not required to grant the request, but we will comply with any request granted;
- Request and receive from us a paper copy of the most current Notice of Privacy Practices for Protected Health Information ("Notice");
- Request that you be allowed to see and get a copy of your protected health information. You may make this request in writing. We have a form available for this type of request.
- Have us review a denial of access to your health information—except in certain circumstances;
- Ask us to change your health information. You may give us this request in writing. You may write a statement of disagreement if your request is denied. It will be stored in your record, and included with any release of your records.
- When you request, we will give you a list of disclosures of your health information. The list will not include disclosures to third party payors. You may receive this information without charge once every 12 months. We will notify you of the cost involved if you request this information more than once in 12 months.
- Ask that your health information be given to you by another means or at another location. Please sign, date, and give us your request in writing.
- Cancel prior authorizations to use or disclose health information by giving us a written revocation. Your revocation does not affect information that has already been released. It also does not affect any action taken before we have it. Sometimes, you cannot cancel an authorization if its purpose was to obtain insurance.

For help with these rights during normal business hours, please contact The Ability Center HIPPA Privacy Officer at 505-526-5016.

Our Responsibilities

We are required to:

- Keep your protected health information private;

- Give you this Notice;
- Follow the terms of this Notice.

We have the right to change our practices regarding the protected health information we maintain. If we make changes, we will update this Notice. You may receive the most recent copy of this Notice by calling and asking for it or by visiting our office to pick one up.

To Ask for Help or Complain

If you have questions, want more information, or want to report a problem about the handling of your protected health information, you may *contact:*

The Ability Center
715 E Idaho Ste 3E, Las Cruces, NM, 88001, 505-526-5016

If you believe your privacy rights have been violated, you may discuss your concerns with any staff member. You may also deliver a written complaint to The Ability Center HIPPA Privacy Officer at our office. You may also file a complaint with the U.S. Secretary of Health and Human Services.

We respect your right to file a complaint with us or with the U.S. Secretary of Health and Human Services. If you complain, we will not retaliate against you.

Other Disclosures and Uses of Protected Health Information

Notification of Family and Others

- Unless you object, we may release health information about you to a friend or family member who is involved in your health care. We may also give information to someone who helps pay for your care. We may tell your family or friends your condition and if you are in a hospital. In addition, we may disclose health information about you to assist in disaster relief efforts.

  You have the right to object to this use or disclosure of your information. If you object, we will not use or disclose it.

We may use and disclose your protected health information without your authorization as follows:

- With health researchers—if the research has been approved and has policies to protect the privacy of your health information. We may also share information with health researchers preparing to conduct a research project.
- To Funeral Directors/Coroners consistent with applicable law to allow them to carry out their duties.
- To Organ Procurement Organizations (tissue donation and transplant) or persons who obtain, store, or transplant organs.
- To the Food and Drug Administration (FDA) relating to problems with food, supplements, and products.

- To comply with workers' compensation laws–if you make a workers' compensation claim.

(13)

- For Public Health and Safety purposes as allowed or required by law:
  - to prevent or reduce a serious, immediate threat to the health or safety of a person or the public.
  - to public health or legal authorities
    - to protect public health and safety
    - to prevent or control disease, injury, or disability
    - to report vital statistics such as births or deaths.

- To report suspected abuse or neglect to public authorities.

- To Correctional Institutions if you are in jail or prison, as necessary for your health and the health and safety of others.

- For Law Enforcement purposes such as when we receive a subpoena, court order, or other legal process, or if you are the victim of a crime.

- For Health and Safety oversight activities. For example, we may share health information with the Department of Health.

- For Disaster Relief Purposes. For example, we may share health information with disaster relief agencies to assist in notification of your condition to family or others.

- For Work-Related Conditions That Could Affect Employee Health. For example, an employer may ask us to assess health risks on a job site.

- To the Military Authorities of U.S. and Foreign Military Personnel. For example, the law may require us to provide information necessary to a military mission.

- In the Course of Judicial/Administrative Proceedings at your request, or as directed by a subpoena or court order.

- For Specialized Government Functions. For example, we may share information for national security purposes.

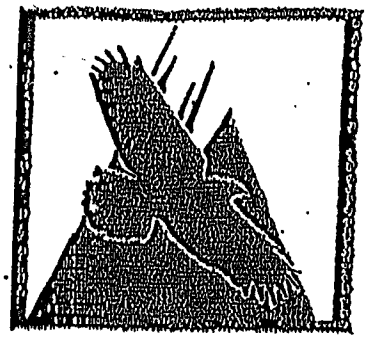
Other Uses and Disclosures of Protected Health Information

- Uses and disclosures not in this Notice will be made only as allowed or required by law or with your written authorization.

Website

- We have a Website that provides information about us. For your benefit, this Notice is on the Website at this address: www.theabilitycenter.org.

Effective Date: April 14th, 2004.



The Ability Center

715 E. Idaho Ave. Ste 3E
Las Cruces, NM 88001-4702
Ph: 575-526-5016 Fx: 575-526-1202
www.theabilitycenter.org

Time Requested: _____ Phone _____

In Person: ☐
By Phone: ☐

Person taking call _____

Time taken _____

CLIENT COPY

Consumer name: _____

Check made Payable: _____

Today's Date: _____

Amount Requested: _____

Purpose: _____

Date Needed _____

Pickup ☐ Mail ☐ Address _____

Requests no delineated in the Consumers' Budget and over $100 requires authorization signature from Payee below:

Signature: _____ Date: _____

No Extra Checks will be disbursed the first week of the month except only the check that was originally set up will be delivered. I understand that there is a 24-hour advance notice before 1:00 p.m. After 1:00 p.m., it will be 48 hours for this request and there must be enough funds in my account to cover the amount of the request. Should there not be enough funds, the request may be approved for a lesser amount or be denied.

Request: Approved ☐
Denied ☐

Different Amount Approved If Any: _____

Reason Denied or Different Amount: _____

_____ Payee Advocate Initials

_____ Date

NO EXTRA CHECKS WILL BE DISBURSED THE FIRST WEEK OF THE MONTH EXCEPT ONLY THE CHECK THAT WAS ORIGINALLY SET UP WILL BE DELIVERED

Address: _____

_____

Phone Number: _____

II. Type of Request (Check Appropriate Box)

☐ Service Request

☐ Service Change

III. Service Request/Change Description

Write your description in the box:

CLIENT COPY

IV. Certification: I, the consumer named above, make the mentioned service request or change stated on this form. By making this request, I hold the Ability Center free of any liability that may result from this service request or change. My signature below states that I understand this statement.

_____

_____ _____

Consumer Signature Date

_____ _____

Staff Signature Date

THE ABILITY CENTER FOR INDEPENDENT LIVING

Providing and (or) locating necessary support services for persons with disABILITIES that promote their independence and full integration in their community as active equal citizens.

715 E. Idaho Ave. Ste 3E Las Cruces, NM 88001-4702 Ph:(575) 526-5016 Fax: (575) 526-1202 www.theability-center.org

Required Information

☐ Current State issued ID, Passport

☐ Social security Card

☐ Medicaid

☐ Medicare

☐ Original Birth certificate

☐ Need a copy of all the bills.

☐ Housing Information, rental or lease agreement

☐ Landlord Name: _____

☐ Address: _____

☐ Phone Number: _____

Signature: _____ Date: _____

Payee required info MAP 1-6-10

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 The Ability Center, Las Cruces, NM 88001 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

SOCIAL SECURITY ADMINISTRATION | TOE 250 | Form Approved OMB No. 0960-0014

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 [X] 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.)

CLIENT STATED HE/SHE REQUIRED TO HAVE A REPRESENTATIVE.

[ ] Claimant is a minor child

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

19 YEARS EXPERIENCE AS A REPRESENTATIVE AND CAN PROVIDE OTHER SUPPORT SERVICES.

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
[X] Visits at least once a week.
[X] By other means. Explain: PHONE CALLS, TEXTS, EMAIL.

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? [X] 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. FEE FOR SERVICE AMOUNT STARTING MONTH FIRST DEPOSIT RECEIVED

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

11. (a) Enter the name of the institution THE ABILITY CENTER

(b) Enter the EIN of the institution 85-0384782

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 _____)
- [ ] AFDC (County & State _____)
- [ ] Other Welfare (describe _____)
- [ ] Other (describe _____)

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

How long have you been employed by this employer? _____

(If less than 1 year, enter name and address of previous employer in Remarks.)

16. (a) Have you ever been convicted of a felony? [ ] YES [X] 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 [X] 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? _____

17.	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_____
18.	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)*	Telephone number(s) at which you may be contacted during the day 575-526-5016

Print Your Name & Title *(if a representative or employee of an institution/organization)*
ALBERTO MONTOYA, EXECUTIVE DIRECTOR

Mailing Address *(Number and street, Apt. No., P.O. Box, or Rural Route)*
715 E. IDAHO AVE STE 3E LAS CRUCES, NM 88001-4702

City and State	Zip Code	Name of County
LAS CRUCES, NM	88001-4702	DOñA ANA

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 ADMINISTRATION TOE 250 Form Approved OMB No. 0960-0014

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)*	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)*

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

City and State	Zip Code	Name of County

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)*

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) and 205(j) of the Social Security Act, as amended, authorize us to collect this information. We will use the information you provide to determine if you are qualified to serve as a representative payee. Furnishing us this information is voluntary. However, failing to provide all or part of the information could 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 for determining continuing eligibility. However, we may use it for the administration and integrity of our 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 the following: 1. To enable a third party or an agency to assist us in establishing rights to our benefits and coverage; 2. 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); 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 and improvement of our programs. (e.g., to the Bureau of Census and to private entities under contract with us).

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. We use the information from these matching programs 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.

A complete list of routine uses for this information is available in our Privacy Act Systems of Records Notice entitled, Master Representative Payee File, 60-0222. Additional information regarding these and other systems of records notices are available on-line at www.socialsecurity.gov or at your local Social Security office.

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.*

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) and 205(j) of the Social Security Act, as amended, authorize us to collect this information. We will use the information you provide to determine if you are qualified to serve as a representative payee. Furnishing us this information is voluntary. However, failing to provide all or part of the information could 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 for determining continuing eligibility. However, we may use it for the administration and integrity of our 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 the following: 1. To enable a third party or an agency to assist us in establishing rights to our benefits and coverage; 2. 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); 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 and improvement of our programs. (e.g., to the Bureau of Census and to private entities under contract with us).

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. We use the information from these matching programs 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.

A complete list of routine uses for this information is available in our Privacy Act Systems of Records Notice entitled, Master Representative Payee File, 60-0222. Additional information regarding these and other systems of records notices are available on-line at www.socialsecurity.gov or at your local Social Security office.

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.*

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) and 205(j) of the Social Security Act, as amended, authorize us to collect this information. We will use the information you provide to determine if you are qualified to serve as a representative payee. Furnishing us this information is voluntary. However, failing to provide all or part of the information could 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 for determining continuing eligibility. However, we may use it for the administration and integrity of our 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 the following: 1. To enable a third party or an agency to assist us in establishing rights to our benefits and coverage; 2. 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); 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 and improvement of our programs. (e.g., to the Bureau of Census and to private entities under contract with us).

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. We use the information from these matching programs 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.

A complete list of routine uses for this information is available in our Privacy Act Systems of Records Notice entitled, Master Representative Payee File, 60-0222. Additional information regarding these and other systems of records notices are available on-line at www.socialsecurity.gov or at your local Social Security office.

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.*

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)
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