City and County of San Francisco
Edwin Lee, *Mayor*

Department of Aging and Adult Services
Shireen McSpadden, *Executive Director*

Representative Payee Program Unit
MARY ANN WARREN, *Assistant Director of Programs*

Deputy Jim Abbeduto, *Unit Supervisor*
Direct Dial (415) 355-3591

September 28, 2016

Dear Agency/Program Director and Case Managers:

The enclosed application packet is to be used for new referrals for representative payee services for the City & County of San Francisco Rep-Payee Program. It has been edited as recently as **September 2016.** Therefore, please destroy any earlier versions of the application packet.

If you wish to copy the application packet for your own use or for others in your organization, you may do so. Social Security has strict guidelines for the various forms that they receive from our office, and they have a habit of returning applications to us when forms are not presented to them in the format they request. That, in turn, slows down the whole process.

If you have any questions, please do not hesitate to call Rep-Payee Supervisor Jim Abbeduto at (415) 355-3591, or send him an e-mail at James.Abbeduto@sfgov.org.

Thank you very much for your attention to this important matter.

Sincerely,

Jim Abbeduto
Rep-Payee Program Supervisor

Enclosures

## INSTRUCTIONS TO THE APPLICATION FOR THE S.F. REP-PAYEE PROGRAM

***IMPORTANT NOTE:* We require original signatures for *each* section of the application packet. Please use BLUE INK to complete all forms. See the next page for the mailing address where you should submit the ORIGINAL application and supplemental documentation. *COPIES, FAXES, AND INCOMPLETE APPLICATIONS CANNOT BE ACCEPTED*.**

The Referral Application PACKET consists of the following set of documents:

**A. Referral Application for San Francisco Representative Payee Program:** The revision date at the bottom of the page is Rev. Sept. 2015. Complete the two-page Referral Application **IN FULL**, using blue ink, if possible. **PRINT CLEARLY. DO NOT OMIT ANY QUESTION OR IT WILL BE RETURNED TO YOU FOR MORE INFORMATION, AND THIS WILL DELAY THE PROCESS.** Next of kin information is important for us to have in the event the client dies and we need to notify a family member (i.e., parent, sibling, aunt, uncle, cousin, niece, nephew).

**B. Physician's/Medical Officer's Statement of Patient's Capability to Manage Benefits:** This two-page document *must have an original signature* (request blue ink). On page two in the upper section, the box for "No" must be checked in order for the client to qualify for the program. AND a ***detailed*** reason must be given. For LPS clients, this form is not required. [Form SSA-787 (7-1992)]

**C. Advanced Notification of Representative Payment:** This one-page form *must be an original, signed by the client*. In the case of LPS court ordered conservatorships where the client cannot sign, the LPS conservator must sign and date the form. [Form SSA-4164 (9-94)]

**D. San Francisco DAAS Rep-Payee Program Disbursement Request Form:** This one-page form is for the case manager to use each time he/she requests a monthly set up to be arranged for the client; each time the case manager requests Personal and Incidental (P&I) funds for the client, each time the case manager makes special requests for a check; and each time the client moves (even if the move is to a hospital for ANY length of time for one night or more). With this application, simply provide original signatures at the bottom of the form.

**E. OTHER DOCUMENTATION:** If your client was not born in the US but is now a citizen, Social Security requires proof of Citizenship and/or Naturalization papers. If the client is still not a citizen but is a resident alien, Social Security requires proof of status. Please provide copies of supporting documents with this application.

**F. Evidence of Other Assets:** We need to see evidence of other assets such as a copy of bank statements, copies of life insurance policies, etc., in order to document all of the client's sources of income for Social Security.

**G. Appointment of Representative:** Medi-Cal Form MC 306 *must be an original signed by client* (request blue ink). This form allows the Rep Payee to contact Medi-Cal on client's behalf.

## WHERE TO SEND YOUR REP-PAYEE APPLICATION FORM

**Only submit an original application (with all supplemental documentation STAPLED to the application). Do not send a copy or a faxed version to our office.** The address is:

San Francisco Rep-Payee Program
Attention: Unit Supervisor
1650 Mission Street, 4th Floor
San Francisco, CA 94103
Telephone: (415) 355-3555

## IMPORTANT REMINDER

All clients must have a caseworker to be accepted into the Rep-Payee Program. Caseworkers must notify our office every time a client moves, or goes to the hospital or jail, or goes AWOL.

## HOW LONG WILL THE PROCESS TAKE?

Depending on the backlog of applications, it may take as long as 90 days from the time an application is submitted to the Rep-Payee Program for the client to be "picked up". Once a client is accepted into the Rep-Payee Program, his or her case is assigned to a deputy in the program unit. That deputy works with Social Security to get the client's benefits established through our office. Depending on the workload at Social Security, it may take a month or two for funds to be rerouted through our office. The deputy will contact the case manager assigned to the case when funds start to come in for the client. **In the meantime, it is important to send changes of address and changes of case manager status to the Rep-Payee Program unit, so we are made aware of these important details and have correct information for fund distribution.** Please do not call for a status report about your client's application until the 90-day time period has passed.

City and County of San Francisco
Edwin M. Lee, *Mayor*

Department of Aging and Adult Services
Shireen McSpadden, *Executive Director*

Representative Payee Program

September 28, 2016

To All Case Managers:

## NOTICE OF NEW FEE SCHEDULE FOR THE REP PAYEE PROGRAM

As of September 2011, the San Francisco Public Guardian Rep Payee Program has been approved to collect a fee from monthly Social Security benefits. This fee will enable the Rep Payee Program to continue to provide service.

Social Security allows us to collect a fee of 10% of the total benefit up to maximum of $41 per month. We understand that may cause a hardship for some clients so we have decided not to collect fees from any client who has a balance under $500 at the end of the month. This approach will have the least impact on the clients and still enable the Rep Payee Program to continue to provide service. The following is the guidelines that we will use to determine fees.

### Rep Payee Fee Guidelines

1) The client must be receiving SSI and or SSA benefits for the month that fee is collected.
2) The client must have a balance of $500 or more in their trust account on the 25th of the month.
3) The fee allowed is 10% of total monthly Social Security benefit but cannot exceed $41.00.
4) The client's status must be one of the following:
   a. Homeless
   b. Board and Care
   c. Independent Living
   d. SNF
   e. Acute (less than full calendar month)
5) If the client receives a retro benefit check, fees can be taken for past months that met the qualifications above.

Do not collect fees from the following clients:
1) Clients that receive only VA benefits.
2) Clients that are in a SNF and receive only $50 SSI per month.
3) Clients with the following status:
   a. Closed
   b. Deceased
   c. IMD
   d. Jail
   e. Acute (full calendar month)

**If you have any questions or concerns you may contact me at (415) 355-3591 or send an email to James.Abbeduto@sfgov.org.**

Sincerely,

James Abbeduto
Rep Payee Supervisor

**City and County of San Francisco**
**Dept. of Aging & Adult Services**

**Representative Payee Program**
**1650 Mission St., 4th Floor**
**San Francisco, CA 94103**
**Tel: (415)355-3555 Fax: (415)355-3566**

## REFERRAL APPLICATION FOR SAN FRANCISCO REPRESENTATVIE PAYEE PROGRAM

*Read instructions carefully *Use Blue Ink*Print Clearly*Answer every question Attach additional pages if needed*

Today's Date: 11/14/2017

From: Person completing this application on behalf of client (Include name, facility/agency, tel., Fax and Email: _____

Check All that Apply: ☐New Application ☐Reinstatement ☐Transfer From another Payee ☐LPS

*If reinstatement, please provide details of case: _____

*If from another Payee please provide info: _____

Briefly describe why this case is being referred: _____

Is the client Conserved: ☐Yes ☐No (describe) _____

Name, Address, Phone, Fax and Email of Conservator: _____

Client's Legal First Name: _____

Client's Legal Middle Name: _____

Client's Legal Last Name: _____

Mother's maiden Name: _____

Aliases used by client: _____

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**Social Security Number of Client**: _____

Date of Birth: City, State and County of Birth: _____

Client is: (check one) ☐U.S. Citizen ☐ Naturalized U.S. Citizen ☐ Resident Alien ☐ Other (describe with date of entry into country/list alien number)

*Staple copies of supplemental documentation to application for any status other than U.S. citizen*

Sex: ☐Male ☐ Female ☐ Transgender: How does client identify? _____

Ethnicity: _____ Primary Language spoken: _____

Does client have a history of violence: ☐Yes ☐ No

Is client a Veteran? ☐No ☐ Yes Claim Number: _____

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*****Please Note That Our Office Must Be Notified Every Time Client Moves*****

Current Living Situation: ☐ Homeless (when? ) Board & Care☐

☐Psychiatric Facility (Locked) ☐IMD ☐ Acute Hospital ☐ LTC/SNF ☐ Independent Living (describe) _____

☐Other (describe) _____

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Name of Current Residence: _____

Address of Residence: _____

City, State, Zip Code: _____

Tel/Fax/Email: _____

Are cooking facilities available anywhere in the building? ☐Yes ☐ No

Are meals otherwise provided? ☐ Yes ☐ No

Date client moved into this residence/admission date into facility: _____

CURRENT MAILING ADDRESS (List "Care of' Individual if necessary): _____

LEGAL MARITAL STATUS: ☐Never Married ☐ Legally Married ☐ Legally Separated
☐ Legally Divorced ☐ Registered Partnership ☐ Widow/Widower ☐ Other: _____
Name, Address, Phone and SSN of Spouse or Legal Partner: _____________

List Names and Ages of all Dependents: _____

Is the client the legal guardian of any of these dependents? _____ Pays Child Support Only?
_____
Does the client RECEIVE child support? ☐ No ☐ Yes (Amount/Month) _____ ___________________
Next of Kin Information: We need to know the name(s) of Next of Kin in case of emergency or death. Provide name, address, phone and email address for any of the following: Parent, child, sibling aunt, uncle, cousin, niece, nephew: _____
_________________________________________________________________________________

Does the client have any of the following? (List names, address of plan administrator, policy number, and description of plan)
Health insurance? _____
Supplemental Health Insurance? _____
Social Security Part-D Provider? _____
Life Insurance? _____
Burial or Cremation Pre-need or Plot? _____ _______________________________________________
Has the client written a will? If so, where is the original? _____

Is the client claiming a DISABILITY with Social Security, SSI, Medical or VA? ☐ No ☐ Yes If yes, please list the name of disability: _____
List the DATE of the ONSET OF THE DISABILITY: _____*(EXTREMELY* Important!)

Income benefits the client receiving (Employment, SSI, SSA, VA, Private Pension, Alimony… or *None)* List all sources and amount of income: _____

List name and address of any employer: _____

Where are checks currently being sent? _____

Does the client have any of the following? ☐House ☐Car ☐Trust Fund ☐Alimony
☐Bank Account(s) ☐Savings Bonds ☐Stock/Mutual Fund Investments ☐Safe Deposit Box
☐Private Family Support ☐Other: _____
Are there any trusted family members, friends or neighbors who could be named as a Rep Payee?. ☐ No ☐ Yes: _____

**The client will be case managed by** *(please notify this office of any changes):*
Name: _____ Phone: _____ Fax: _____
Email: _____ ___________________________ Program Name: _____ _________________________
Address: _____

# PHYSICIAN'S/MEDICAL OFFICER'S STATEMENT OF PATIENT'S CAPABILITY TO MANAGE BENEFITS

TIME IT TAKES TO COMPLETE THIS FORM
We estimate that it ill take you about 5 minutes to complete this form. This includes the time it will take to read the instructions, gather the necessary facts and fill out the form. If you have comments or suggestions on this estimate, or on any other aspect of this form write to the Social Security Administration, ATTN: Reports Clearance Officer, 1-A-21 Operations Bldg., Baltimore, MD 21235-0001, And to the Office of Management and Budget, Paperwork Reduction Project (0960-0024), Washington, D.C. 20503. **Send only comments relating to our estimate or other aspects of this form to the offices listed above. All requests for Social Security cards and other claims-related information should be sent to your local social Security office, whose address is listed in your telephone directory under the Department of Health and Human Services.**

In Replying use this address:
SOCIAL SECURITY ADMINISTRATION

**TELEPHONE NUMBER** (Including Area Code)
(    )

**DATE**

**SSA CONTACT**

**IDENTIFYING INFORMATION (SSA or**
If different from patient

**NAME OF WAGE EARNER OR SELF-EMPLOYED PERSON**

**SOCIAL SECURITY NUMBER**
__ __ __ / __ __ / __ __ __ __

This report is authorized by sections 205(a) and 205 (j) of the Social Security Act, as amended (42 U.S.C.) 405(a) and 405(j). While you are not required to respond, your cooperation will help us decide whether any Social Security benefits that may be due should be paid directly to the patient or to someone else on the patient's behalf. Your cooperation in completing and returning this statement will be appreciated.

We may also use the information you give us when we match records by computer. Matching programs compare our records with those of other Federal, State, or local government agencies. Many agencies may use matching programs to find or prove that a person qualifies for benefits paid by the Federal government. The law allows us to do this even if you do not agree to it. These and other reasons why information your provide may be used or given out are explained in the Federal Register. If you want to learn more about this, contact any Social Security office.

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 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. 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

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 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 sigh 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.

**HEREBY CERTIFY THAT THE ABOVE STATEMENTS AND ANSWERS ARE TRUE TO THE BEST OF MY KNOWLEDGE.**

| NAME OF PHYSICIAN/MEDICAL OFFICER *(Please print)* | TITLE |
|---|---|
| ADDRESS *(Number and street, City, State, And ZIP Code)* | TELEPHONE NUMBER *(Including Area Code)* ( ) |
| NATURE OF PHYSICIAN/MEDICAL OFFICER | DATE |

**FORM SSA-787** (7-92)

*U.S. Government Printing Office: 1994 --300-948/00029

# Advance Notification of Representative Payment

| Name of Wage Earner, Self-Employed Person or SSI Claimant | Social Security Number<br><br>– – |
| --- | --- |
| 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) |

# APPOINTMENT OF REPRESENTATIVE

**SECTION I. TO BE COMPLETED BY APPLICANT/BENEFICIARY**

| Name | Case number *(optional)* | Date |
|---|---|---|
| | | |

I appoint this individual ______________________ / ______________________
***Name of individual*** ***Name of organization***

______________________________________________
Complete address Telephone number

as my authorized representative to accompany, assist, and represent me in my application for, or redetermination of, Medi-Cal benefits.

**THIS AUTHORIZATION ENABLES THE ABOVE NAMED INDIVIDUAL TO:**

- submit requested verifications to the county welfare department;
- accompany me to any required face-to-face interview(s);
- obtain information from the county welfare department and from the State Department of Social Services, Disability Evaluation Division, regarding the status of my application;
- provide medical records and other information regarding my medical problems and limitations to the county welfare department or the State Department of Social Services, Disability Evaluation Division;
- accompany and assist me in the fair hearing process; and
- receive one copy of a specific notice of action from the county welfare department, at the request of the applicant/beneficiary.

**I UNDERSTAND THAT I HAVE THE RESPONSIBILITY TO:**

- complete and sign the Statement of Facts;
- attend and participate in any required face-to-face interview(s);
- sign MC 220 (Authorization for Release of Medical Information);
- provide all requested verifications before my Medi-Cal eligibility can be determined; and
- accept any consequences of the authorized representative's actions as I would my own.

**I UNDERSTAND THAT I HAVE THE RIGHT TO:**

- choose anyone that I wish to be my authorized representative;
- revoke this appointment at any time by notifying my Eligibility Worker; and
- request a fair hearing at any time if I am not satisfied with an action taken by the county welfare department.

| Applicant/Beneficiary's signature | Date |
|---|---|
| ➤ | |

Address

**SECTION II. TO BE COMPLETED BY THE AUTHORIZED REPRESENTATIVE NAMED.** ***LAW FIRMS, ORGANIZATIONS, AND GROUPS MAY REPRESENT THE APPLICANT/BENEFICIARY BUT AN INDIVIDUAL MUST BE DESIGNATED AS THE CONTACT PERSON TO ACT ON THE APPLICANTS/BENEFICIARIES BEHALF.***

**I HEREBY ACCEPT THE ABOVE APPOINTMENT AND UNDERSTAND THAT:**

- the applicant/beneficiary may revoke this authorization at any time and appoint another individual(s) to act as his/her authorized representative;
- I have no other power to act on behalf of the applicant/recipient, except as stated above;
- I may not act in lieu of the applicant/beneficiary; and
- I may not transfer or reassign my appointment without a new Appointment of Representative form being completed by the applicant/recipient.

**I CERTIFY THAT:**

- I have not been suspended or prohibited from practice before the Social Security Administration
- I am not, as a current or former officer or employee of the United States, disqualified from acting as the applicant's representative; and
- I am known to be of good character.

This authorization is recognized for one year from the date signed by the applicant unless revoked earlier as described in Section 1 above.

| Authorized representative's signature | Employed by | Date | Telephone number |
|---|---|---|---|
| ➤ | | | |

***COUNTY USE ONLY***

Date verbal request to revoke received ______ Date written request to revoke received ______ Request received from: ______

EW name: ______________________ Telephone number: ______

# SAN FRANCISCO DAAS REP-PAYEE PROGRAM

1650 Mission Street, 4th Floor, San Francisco, CA 94103 – Ph: (415) 355-3555 – Fax: (415) 355-6738

## *DISBURSEMENT REQUEST FORM*

CLIENT NAME ______________________ S.S.No.: ___ - ___ - ______
CASE MANAGER: ______________________ AGENCY: ______________________
PHONE #: ( ) ___ - ______ FAX #: ( ) ___ - ______ DATE: ___ / ___ / ______

☐ CHANGE OF ADDRESS – Date of Move: ___ / ___ / ______ ☐ B/C ☐ INDEP. ☐ IMD ☐ ACUTE
☐ RENT PAYMENT – Effective Date: ___ / ___ / ______ Cooking Facilities ☐ Yes ☐ No
Rent Amount: ______________________ ☐ Monthly
Payable to: ______________________ ☐ One Time Only
Address: ______________________ ☐ **MAIL OUT**
______ , ______________________ ☐ **PICK UP**
Telephone No.: ( ) ___ - ______ **(BY CM ONLY)**

☐ **PERSONAL AMOUNT: $** ______________ No. of checks at this amount: ______
Payable to: ______________________ Effective Date: ___ / ___ / ______
☐ **PICK UP (BY CASE MANAGER ONLY)** ☐ **One time only**
☐ **MAIL OUT – mail to:** ☐ **Once a month***
☐ Above address ☐ **Twice a month***
☐ Other address: c/o ______________________ ☐ **Four a month***
______________________ **(*On going, unless**
______ , ______________________ **Changed)**

☐ **SPECIAL CHECK REQUEST:** Amount: $ ______________ ☐ **PICK UP (BY CM ONLY)**
☐ **MAIL OUT**

Payable to: ______________________
**(Name and address required)**
c/o ______________________
______________________
______ , ______________________
Purpose of check: ______________________

______________________ ______________________ ______________________
**Case Manager's Signature** **Supervisor's Signature** **Client's Signature**

**CONFIDENTIAL – This facsimile transmission and any accompanying pages may contain privileged and confidential information protected by federal and state laws. The information is intended only for the use of the addressee or the addressee's agent. Please be aware that any dissemination, distribution or copying of this communication is strictly prohibited and may be unlawful. If you have received this fax in error, please call us immediately upon receipt and return the original massage to us at the above address via the U. S. Postal Service.**