APPLICATION PACKET
REPRESENTATIVE PAYEE PROGRAM

Thank you for choosing Mental Health America to serve as your Organizational Representative Payee. We ask that you please review and complete the enclosed Application Packet. All information listed is required for processing. In the case that we receive an incomplete application packet or missing information, we will return the packet for completion and delays in processing may occur.

A. MHA's Program Application Packet Includes:

Section 1: Personal Information

Section 2: Income & Employment Information

Section 3: Medical Information

Section 4: Family Information

Section 5: Rep Payee & Legal Information

Section 6: Caseworker/Referral Source Contact Information

Section 7: Psychiatric & Social Background

Section 8: Signature of Agreement

What You Will Need: Checklist for your initial budget meeting at MHA is included

B. Physician's/Medical Officer's Statement of Patient's Capability to Manage Benefits:

The Social Security Administration Office will also need a completed and signed Form SSA-787. Please ensure this statement is attached to the application before submitting to MHA's office.

C. Monthly Program Service Fee:

MHA charges a monthly service fee while enrolled in the Representative Payee Program. The amount of this fee is established by The Social Security Administration. Please contact us for the current fee rate.

Please submit the completed Application Packet to:

MHA - York County Office Fax: (717) 843-0185 Mail: 36 South Queen Street York, PA 17403	MHA - Adams County Office Fax: (717) 339-0611 Mail: 304 York St., Suite F, Gettysburg, PA 17325

Thank you again for choosing MHA. We look forward to working with you!

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of York and Adams Counties

MENTAL HEALTH AMERICA OF YORK AND ADAMS COUNTIES REPRESENTATIVE PAYEE PROGRAM

WHO IS A REPRESENTATIVE PAYEE

A Representative Payee (or Financial Case Manager) is someone who manages an individual's money to ensure the individual's needs are met. At MHA, your rep payee will receive and manage benefits and payments on your behalf and use them for your best interest and needs. This will include managing payments for food, housing, clothing, medical care, personal items, savings, and/or to satisfy past debt.

HOW IT WORKS

Upon entrance into the Representative Payee Program, an initial budget meeting will be scheduled. This meeting will generally take place at MHA, located at 36 South Queen Street, York, PA 17403 (York County Office) or 304 York Street, Suite F, Gettysburg, PA 17325 (Adams County Office), unless other arrangements are made prior to the meeting. You and your case manager(s) should plan to attend this meeting, as it is the first step in determining how your money will be spent.

At your budget meeting, you, your caseworker(s) and your payee will discuss how much money you receive every month and how you will spend it. After reviewing your benefits and payments, your payee will set up an individual monthly budget to best meet your current needs. Remember, your suggestions and ideas are important, so always feel free to share them.

After your first meeting, future budget meetings will be scheduled at the end of the previous budget meeting, or on an as-needed basis, in consideration of your budget stability, and your individual need. At least one budget meeting will be scheduled per year.

If you are currently working or start to work while you are part of this program, your earnings or any other money you receive on a regular basis will need to be reported to your Representative Payee. It will also be important for your Payee to know what public assistance programs you are currently receiving (Food Stamps, LIHEAP, CAP/PCAP, Rent Rebate) so they are best able to serve you.

BENEFITS OF BEING IN THE PROGRAM

By being part of the Representative Payee Program, we hope that you will be relieved of the financial burden of trying to manage your money and pay your bills. MHA will ensure that all of your basic needs are met. By doing so, you should see an increase in your financial stability, be able to avoid eviction due to rent not being paid, and lessen hospitalizations due to financial stress.

Mental Health America of York and Adams Counties

DATE RECEIVED:

APPLICATION PACKET
REPRESENTATIVE PAYEE PROGRAM

I - PERSONAL INFORMATION (Please print and complete all sections for the individual you are referring)

Name (Last, First) ____________________

Date of Birth: ____________________ City & State of Birth: ____________________

Social Security Number: ____________________ Ethnicity: ____________________

Marital Status: ____________________ Gender: ____________________

Home Phone: ____________________ Cell Phone: ____________________

Email: ____________________

Current Living Situation (please check all that apply):

☐ Alone	☐ With family or relative	☐ Group Home
☐ Own Home	☐ With friend or roommate	☐ Boarding Home or Care Facility
☐ Apartment	☐ Public Institution	☐ Nursing Home
☐ Homeless	☐ Private Institution	☐ Other:

If you live with others, please list who they are:

	NAME	RELATIONSHIP
(a)		
(b)		
(c)		

Residential Address:	
Mailing Address: (If different than Residence)	

Do you expect the current living situation to change in the next year?

Employed: ☐ Yes ☐ No If Yes, please explain: ____________________

If you are in a Rental/Lease Agreement, please complete the following:

Landlord Name: ____________________

Landlord Phone: ____________________

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II - INCOME AND EMPLOYMENT INFORMATION

SSI:	$	Pension or Annuity:	$
SSD:	$	Wages:	$
SSA:	$	Food Stamps:	$
Veterans:	$	Other:	$

Employed: ☐ Yes ☐ No If yes, please answer boxes a-e below:

a) Employer Name:

b) Employer Address:

c) Employer Phone:

d) Earnings Per Month: e) Hours Per Month:

Savings Account	☐ Yes ☐ No	Acct #:		Bank Name:
Checking Account	☐ Yes ☐ No	Acct #:		Bank Name:
Burial Reserve	☐ Yes ☐ No	Acct #:		Bank Name:

Life Insurance Policy: ☐ Yes ☐ No Policy #:

Name of Life Insurance Company:

Address of Life Insurance Company:

If the individual is receiving benefits from a relative (i.e. survivor's benefits from deceased husband/wife, benefits from a divorced spouse, or benefits for a child) please provide the relative's information below:

Relative's Name (Last, First): Soc. Sec. No.

Relationship to Individual:

Relative's Name (Last, First): Soc. Sec. No.

Relationship to Individual:

Mother's Maiden Name:

Father's Full Name:

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III - MEDICAL INFORMATION

Medicaid (Medical Assistance): ☐ Yes ☐ No If yes, answer below

Provider Name: ______

Record Number: ______

Medicare: ☐ Yes ☐ No If yes, answer below

Part D (Prescription) Provider: ______

Other Insurance: ☐ Yes ☐ No If yes, answer below

Provider Name: ______

ID Number: ______

IV - FAMILY INFORMATION

Designated Next of Kin: ______

Address: ______

Phone: ______

Relationship to Individual: ______

V - REP PAYEE & LEGAL INFORMATION

Does this person currently have a Rep Payee? ☐ Yes ☐ No

Please explain below why this person needs a Rep Payee, or why the current Rep Payee can no longer serve them:

______

______

______

Does this person have a court-appointed Legal Guardian or POA? ☐ Yes ☐ No If yes, answer below

Name: ______

Address: ______

Phone: ______

Title: ______

Reason for the appointment: ______

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VI - CASEWORKER/REFERRAL SOURCE INFORMATION

Name: ____________________

Agency: ____________________

Office Phone: ____________________ Cell Phone: ____________________

Email: ____________________

VII - PSYCHIATRIC & SOCIAL BACKGROUND

Axis I: ____________________

Axis II: ____________________

Axis III: ____________________

Axis IV: ____________________

Axis V: GAF #

Please attach a copy of the individual's psychiatric/social background or provide a brief description below.

Description of the Individual's Psychiatric/Social Background:

VIII - SIGNATURE OF AGREEMENT

I affirm that all information provided is true and up to date. I also understand that it is my responsibility to make sure that MHA has complete and accurate information at all times.

I agree that MHA may discuss my case information with my case management services, Social Security Administration, The Dept. of Welfare and vendors regarding my bills and any other agency deemed necessary to ensure proper maintenance of my finances.

Client Name (Printed): ____________________

Client Signature: ____________________ Date:

**** Do you have a current & valid Photo ID?** ☐ **Yes** ☐ **No**

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INITIAL BUDGET MEETING – WHAT YOU WILL NEED

PLEASE BRING THE FOLLOWING ITEMS WITH YOU TO YOUR FIRST BUDGET MEETING:

☐ All Medical Cards

☐ Social Security Card

☐ Current Photo ID or Driver's License

☐ Lease or Mortgage Arrangement

☐ Monthly Income Amounts (SSI, SSDI, PA SSP, Wages, Veteran's, Pension, Trust, Other)

☐ Utility Invoices and Monthly Expenses

☐ Confirmation of any Public Assistance Programs in which you are enrolled (Food Stamps, LIHEAP, CAP/PCAP, Rent Rebates)

☐ Co-Pays and Premiums for Medical Benefits & Medications, and names of Pharmacies used

☐ Any Burial/Preneed/Life Insurance Policies (Irrevocable, Cash Value, Premium)

☐ Copy of Savings/Checking or other Bank Accounts, including Investments. Please bring account number(s).

☐ Paystubs, if employed, as MHA will be responsible for reporting wages to SSA