Mental Health America
of York and Adams Counties

APPLICATION PACKET

Representative Payee Services

Personal Information: (Required for Processing)			
Client Name:			Soc Sec #:
Address:			DOB:
			Birthplace (City/State):
City:	State:	Zip+4:	County:
Mailing Address:			Case Manager/Agency:
			Gender:
City:	State:	Zip+4:	Marital Status: S,M,D,W
Phone/Cell Phone #:		Email:	
What is your diagnosis/disability:	☐ Mental Health	☐ IDD	☐ Both
Explain:			

Emergency Contact/Family: (Required for Processing)	
Name:	Relationship:
Address:	Phone #:
	Email:
Name:	Relationship:
Address:	Phone #:
	Email:

Referral Source: (Required for Processing)		
☐ Social Security Administration	Claim Representative:	
☐ Case Manager/Agency	Name/Agency:	
Address:	Phone #:	Email:
☐ Friend/Relative	Name:	
Address:	Relation:	
	Phone #:	Email:
☐ Other	Name:	
Address:	Relation:	
	Phone #:	Email:

Benefits Receiving (Check all that apply):		
☐ SSA	Amount: $	Claim Number:
☐ SSI	Amount: $	Claim Number:
☐ Other:	Amount: $	Claim Number:
☐ Cash Assistance Amount: $	☐ Food Stamps Amount: $	

Asset Information:			
☐ Savings Account	Bank Name:	Acct #:	Value: $
☐ Checking Account	Bank Name:	Acct #:	Value: $
☐ Burial Account	Bank Name:	Acct #:	Value: $
☐ Burial Plot	Plot Location:		Value: $
☐ Life Insurance	Insurance Company:	Acct/Policy #:	Value: $

Household Information:		
Type of Residence:		
☐ Owns Home	Mortgage Company:	
	Mailing Address:	
	Account #:	Payment Amount: $
☐ Apartment/House Rental	Landlord Name:	
	Mailing Address:	
	Rent Amount: $	Phone #:
☐ Group Home	Provider Name:	
	Address:	
	Room/Board Amt: $	Phone #:
☐ Institution/Other:	Facility Name:	
	Address:	
	Room/Board Amt: $	Phone #:
☐ Homeless:	Name:	
	Address:	
	Rent Amount: $	Phone #:

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

Employment Information		
☐ Not employed – skip this section		
Employer Name:		Phone # :
Employer Address:		☐ Full Time
		☐ Part Time
How many hours per week:	How many hours per day:	Rate of pay: $

Current Payee:		
☐ Own Payee: - **Must provide Social Security Physician's Statement (SSA-787), see attached.**		
☐ Have Payee:	Name:	Phone:
	Address:	Relation:
	Are they no longer willing to be rep payee?	
☐ New Claim: Social Security Deemed Necessary		

The MHA Rep Payee Application Process:

1. When MHA Rep Payee Program receives all of the required information to complete the Program Application, we will then submit the application to the Social Security Administration (SSA). Their process may take at least three months to approve the payeeship.
2. Once we are approved, we will receive a letter from SSA naming us as the payee.
3. We will then send the case manager and applicant an email and/or a phone call to schedule the Initial Budget Meeting.

Other Important Information:

- The purpose of this form is to gather important information about your income and expenses and current money management practices. The more information we have, the better we will be able to meet your needs.
- We cannot create a realistic and sustainable budget if you do not disclose all of your expenses to us. If you remember any additional information that you feel we may need to better serve you, please feel free to contact us at 717-843-6973 ext. 103 or ext. 150.

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 Department of Human Services and vendors regarding my bills and any other agency deemed necessary to ensure proper maintenance of my finances.

Client Name (Printed): ____

Client Signature: ____ Date: ____________________