Monterey County Behavioral Health
Policy and Procedure

Policy Number	433
Policy Title	AS CM Rep Payee Services Eligibility
References	MONTERY COUNTY BOARD OF SUPERVISORS POLICY 432 – ADULT SERVICES/CM REPRESENTATIVE PAYEE SERVICES DELEGATION OF AUTHORITY FOR REPRESENTATIVE PAYEE SERVICES POLICY 434 – ADULT SERVICES/CM REPRESENTATIVE PAYEE SERVICES INTAKE PROCEDURES PUBLIC ADMINISTRATOR – PUBLIC GUARDIAN – CONSERVATOR DIVISION DELEGATION OF AUTHORITY MEMORANDUM OF 12/1/2006 RESOLUTION NO. 82-43 PUBLIC GUARDIAN TO ACT AS REPRESENTATIVE PAYEE
Form	INITIAL ASSESSMENT OF NEED FOR REPRESENTATIVE PAYEE SERVICES (ATTACHMENT 1) PHYSICIAN'S/MEDICAL OFFICER'S STATEMENT OF PATIENT'S CAPABILITY TO MANAGE BENEFITS SSA-787 (ATTACHMENT 2) AGREEMENT WITH MCHD FOR REPRESENTATIVE PAYEE SERVICES (ATTACHMENT 3) ADVANCE NOTIFICATION OF REPRESENTATIVE PAYMENT SSA-4164 (ATTACHMENT 4) MH-112 (ATTACHMENT 5) ANNUAL REVIEW REPRESENTATIVE PAYEE SERVICES (ATTACHMENT 6) INFORMATION UPDATE FORM BHD REPRESENTATIVE PAYEE SERVICES (ATACHMENT 7)
Effective	OCTOBER 1, 1991 REVISED: MAY 20, 2003 REVISED: APRIL 1, 2009 REVISED: JUNE 1, 2010

POLICY

The Monterey County Behavioral Health Division (MCBHD), Adult Services Program, as designated by the Public Guardian Memorandum dated 12/1/2006 and Monterey County Board of Supervisors Resolution No. 82-43, will provide money management through the

Representative Payee Services for eligible adults with a functional mental illness who are either not capable or managing their Social Security Benefits or not capable of directing others how to manage those benefits to meet their basic needs, and there is no other appropriate person available to perform that service.

PROCEDURE

The following eligibility requirements are to be met for participation in the representative payee program:

A. Residency Requirement

1. The consumer is voluntarily living in Monterey County and has the stated intention of making his/her home in Monterey County for other than a temporary purpose.
2. No durational period of residence is required.
3. Active cases that no longer meet the above definition will be closed within 90 days of the date MCHD became aware of the consumer's change of residence.
4. Residency shall be verified and documented in the case file. The consumer's statement, when there is no conflicting evidence, shall be sufficient verification of intent to remain in Monterey County.

B. Management Incapability Requirements

1. A mental incapacity exists when the consumer has a mental illness or impairment that substantially reduces or eliminates the consumer's ability to manage his/her own Social Security benefits and the condition is expected to last longer than 90 days.
2. The case manager will document on the form, Initial Assessment for Representative Payee Services (ATTACHMENT 1), the existence of a mental incapacity as described above and the need for Representative Payee as follows:
    a. A diagnosis of the consumer's condition and explanation of the extend to which it prevents or eliminates or substantially reduces him/her from managing his/her Social Security benefits, or why it reduces or eliminates the ability to direct others to manage those benefits in regard to food, shelter and clothing.
    b. The expected duration of the condition.
    c. The name and title of the professional completing the assessment.
    d. Other acceptable evidence includes written statements of relatives, friends, and other individuals in a position to know and observe the consumer.
3. The treating Psychiatrist will complete a Physician's/Medical Officer's Statement of Patient's Capability to Manage Benefits (Form SSA-787) (ATTACHMENT 2) for consumers who receive Social Security (Social Security Disability Insurance – SSDI) and/or Supplemental Security Income (SSI) payments.

C. Management Alternative Requirement

Representative Payee Services through the Department of Health are provided only as a last resort in order to prevent the consumer's loss of food, shelter, and/or the other basic needs. The case manager shall document the efforts made to prevent the need for a Representative Payee.

The case manager shall document in the case file as per Policy 434 efforts to ensure that there shall be no relative, friend, volunteer, or other agency that is able, appropriate and willing to serve as payee.

D. Voluntary Participation Category

Initial and continued participation in the Representative Payee Services shall be voluntary, whenever possible. There shall be on file a singed "Agreement with MCHD for Representative Payee Services" (ATTACHMENT 3). The signed Agreement shall be completed in duplicate. The original is filed in the case folder and the consumer retains the copy. All requirements of the Representative Payee Services shall be fully explained before the consumer may sign, including the consumer's right to contest the appointment.

The case manager shall also request the consumer to sign the agreement to the appointment of the Department of Health as Representative Payee on Form SSA-4164 Advance Notification of Representative Payment (ATTACHMENT 4). The consumer shall be allowed to participate in the planning to determine how his/her money is spent. Whenever possible, the case plan shall be made with the goal of the consumer becoming his/her own payee.

E. Involuntary Participation Category

After conducting an investigation and assessment of need and securing a completed Physician/Medical Officer's Statement of Patient's Capability to Manage Benefits Form SSA-787, the case manager shall inform the consumer of the reasons for requesting the establishment of the right to object to the appointment.

It is unlikely that some consumers, who are not capable of managing their own funds or directing others to manage them to meet their basic needs, may refuse to voluntarily participate in the Representative Payee Services. The case manager shall request that the consumer sign and state the reasons for their
appeal of the appointment on Form SSA-4164 Advance Notification of Representative Payment.

The Adult Services Program case manager shall identify in the treatment plan the objective of assisting the consumer to achieve the intermediate goal of voluntary participation in the Representative Payee Services in the process of developing the skills to manage their own income whenever possible.

F. Cooperation Requirement

The consumer shall cooperate with the Monterey County Department of Health and other agencies to establish and maintain eligibility for financial benefits and to reconcile overpayment claims with payment sources. Examples of some agencies are the Social Security Administration (SSA) and the Department of Social and Employment Services (DSES). The consumer's statement, when there is no conflicting evidence, shall be sufficient verification of the intent to cooperate.

G. Real Property Requirement

The consumer shall have no real property other than the house that he/she lives in.

H. Cash Assets Requirement

The consumer shall not have cash assets in excess of $2,000.00. Cash assets include cash, checking accounts, life insurance policies with a cash value, and other financial assets that can easily be converted into cash.

The case manager shall secure the consumer's agreement to close all bank accounts, turn over all credit cards, close all credit accounts, and turn over all cash assets to the Representative Payee for management as a condition of participation in the Representative Payee Services. The consumer will sign agreements to those conditions of participation in the Representative Payee Services. The consumer will sign agreements to those conditions of participation and provide the case manager with written confirmation that credit and bank accounts are closed.

The case manager shall immediately complete Form MH-112 (ATTACHMENT 5) upon the receipt of any cash or check assets from the consumer and immediately turn over the assets to the Office of the Public Guardian for deposit in the Representative Payee Trust Account.

I. Periodic Review Requirement

The eligibility and continued need for Representative Payee Services shall be reviewed at periodic intervals as indicated below:

1. Review period intervals are counted beginning with the month following the month in which the case was approved or the month in which the last review was completed.
2. A case review is required within 30 days of the date the case manager became aware that a consumer has significantly changed his/her living arrangement. EXAMPLE: The client leaves a board and care facility and moves into an independent living arrangement.
3. A semi-annual case review shall be completed at six (6) month intervals for all participants. A case may be reviewed more often, if warranted.
4. Each periodic review shall consist of a fact-to-face contact. The review shall include an assessment to determine whether the consumer might be his/her own payee, and if not, whether another capable person is available to serve as payee (ATTACHMENT 6). The review shall evaluate and update the case plan.
5. An annual review shall consist of all the assessments contained in the semi-annual review as well as basic re-determination of eligibility for Social Security benefits and an annual fiscal accounting of the management of Social Security benefits.
6. The Behavioral Health Service Manager shall conduct a quarterly fiscal and service audit of all cases closed during each quarter and ten percent of all cases open by the end of each quarter.

J. Visitation Requirement

Each representative payee consumer will be visited as follows:

1. At a minimum of intervals. The Representative Payee is also required to make visits at the time of the semi-annual and annual reviews.
2. The purposes and goals of the visits include but are not limited to the following:
   a. Monitor the progress of the service plan.
   b. Determine the consumer's whereabouts.
   c. Review the account/payment schedule with the consumer.
   d. Determine if there are other needs.
   e. Determine if payee services continue to be needed.
   f. Evaluate the appropriateness of the current placement or needed placement.
   g. Evaluate the condition of the home and the consumer.
   h. Determine if the consumer is receiving sufficient incidental funds to meet personal needs.
   i. Determine if additional protective services are needed.

K. Termination

When the Representative Payee makes a determination that the consumer is no longer eligible for Representative Payee Services from the Department of Health, that decision shall be reviewed and approved by the Adult Services Program Manager prior to the notice of intent to terminate being transmitted to the Social Security Administration.

When Representative Payee Services are to be terminated, the Social Security Administration and the Office of the Public Guardian shall receive immediate written notification (ATTACHMENT 7), and the case shall be closed within 90 days of the date that Monterey County Department of Health becomes aware of any one of the following (unless otherwise specified):

1. Consumer dies.
2. Unable to locate consumer for forty-five (45) days. Check returned –consumer whereabouts unknown.
3. Consumer is or will be in jail for more than 90 days.
4. Consumer moves out of the county.
5. When the consumer or another person becomes the payee.
6. Consumer is able to manage his/her own funds.
7. The Social Security Administration grants a request for discontinuance of the Representative Payee Status or names a new Representative Payee.
8. Consumer no longer meets eligibility criteria.

SOCIAL SECURITY NUMBER:_____ DATE OF BIRTH:_____

1. Is client able to manage his/her funds? _____ Yes _____ NO. Describe client's inability/ability to manage own funds. Does client have ability to reason properly? Is client confused and/or disoriented? Does client have impaired judgment? Is client able to communicate with others?

2. Current Diagnosis: _____

3. Expected Duration of the Disability: _____

4. Describe Alternative Money Management Interventions That Have Failed:

5. Describe Who is Being Considered for Role of Representative Payee; Assess their Capability:

6. What are client's current money management needs?
   Shelter_____
   Utilities_____
   Clothing_____
   Medical/Dental_____
   Personal Needs_____

7. Describe the current money management service plan, including goals and time frames.

8. Most Appropriate Payee for Client:
   Name/Address of Capable/Interested Person:

_____ None _____ Monterey County Department of Health

Case Manager Signature_____ Date_____

Unit Supervisor Signature_____ Date_____

INITIAL ASSESSMENT OF NEED FOR REPRESENTATIVE PAYEE SERVICES BEHAVIORAL HEALTH DIVISION JH/RPS-IASS.1 (Rev 11/01) MH368 (Rev 11/01)	CLIENT NAME:_____ PUBLIC GUARDIAN ACCOUNT NUMBER:_____

SOCIAL SECURITY ADMINISTRATION | TOE 850 | Form Appr OMB No. 0960-

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

PAPERWORK REDUCTION ACT NOTICE AND TIME IT TAKES STATEMENT:

The Paperwork Reduction Act of 1995 requires us to notify you that this information collection is in accordance with the clearance requirements of section 3507 of the Paperwork Reduction Act of 1995. We may not conduct or sponsor, and you are not required to respond to, a collection of information unless it displays a valid OMB control number. We estimate that it will take you about 10 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.

In replying, use this address:
SOCIAL SECURITY ADMINISTRATION

TELEPHONE NUMBER (Include Area Code)
( )

DATE

SSA CONTACT

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. Explanations about these and other reasons why information you provide us may be used or given out are available in Social Security Offices. If you want to learn more about this, contact any Social Security Office.

IDENTIFYING INFORMATION (SSA Only)
If different from patient

NAME OF WAGE EARNER OR SELF-EMPLOYED PERSON

SOCIAL SECURITY NUMBER
___ / __ / ____

PATIENT'S NAME		PATIENT'S ADDRESS (Number and Street, City, State and ZIP Code)
PATIENT'S SOCIAL SECURITY NUMBER ___ / __ / ____	PATIENT'S DATE OF BIRTH	

YOUR HELP IS NEEDED

The patient shown above has filed for or is receiving Social Security or Supplemental Security Income payments. We need you to complete the back of this form and return it to us in the enclosed envelope to help us decide if we should pay this person directly or if he or she needs a representative payee to handle the funds. **Please Note:** This determination affects how benefits are paid and has no bearing on disability determinations. 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

Attachment 2

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 sign and date the form.

If "No", please provide a brief summary of the findings that led to this conclusion. Also, complete question 3.

If "unsure", please explain.

3. Do you expect the patient to be able to manage funds in the future (for example, the patient is temporarily unconscious)?

☐ Yes ☐ No

If yes, please explain.

I 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 *(Include Area Code)* ( )
SIGNATURE OF PHYSICIAN/MEDICAL OFFICER	DATE

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

*U.S. Government Printing Office: 2000 — 461-207/20068

MONTEREY COUNTY DEPARTMENT OF HEALTH

REPRESENTATIVE PAYEE SERVICES

AGREEMENT WITH MCHD FOR REPRESENTATIVE PAYEE SERVICES

CLIENT NAME: _____

ADDRESS: _____
Street City Zip Code

TELEPHONE NUMBER: _____ **SOCIAL SECURITY NUMBER:** _____

I, the undersigned, agree to the appointment of the Monterey County Department of Health, Behavioral Health Division, and Adult Mental Services Program (thereafter referred to as (MCHD) as my Representative Payee I understand that by this Agreement, MCHD assumes no legal responsibility or financial liability for me. As my Payee, MCHD will only manage the funds I have on deposit under their Representative Payee Services (RPS). Debts, costs, and/or fees, which I accrue, will be paid by MCHD from the funds I have on deposit in my Representative Payee account. Under no circumstances may MCHD be held liable for payment of claims which exceed the funds I have on deposit with their Representative Payee Services, or for financial liabilities that I incurred before the start of this Agreement, or I assume after the termination of this Agreement for such services.

I agree to close all bank accounts, to turn over all credit cards, to close all credit accounts, and to turn over all cash assets to the MCHD Representative Payee for deposit and management in the Representative Payee for deposit and management in the Representative Payee Services Trust Account. I agree to provide the MCHD with written confirmation that all bank and credit accounts are closed before the appointment of MCHD with written confirmation that all bank and credit accounts are closed before the appointment of MCHD as my Representative Payee becomes effective.

I understand that the basic purpose of this agreement is to engage the MCHD Representative Payee Services to manage my income and assets for my use and benefit. As a participant in the Representative Payee Services, I understand that I have certain rights and responsibilities, as referenced on the reverse side of this form.

I understand that this Agreement **does not mean** that the MCHD becomes my Guardian or Conservator, nor does it assume Power of Attorney over my affairs. This Agreement **does not give** the MCHD the power to dispose of my real property, nor does it give the MCHD Representative Payee the power to sign purchase or lease agreements for me in my name.

I agree and direct that MCHD as my Payee, give highest priority to assuring that their management of my funds provides for my basic needs of **food, shelter, and clothing**; and that my medical and day-to-day personal needs will be met to extent possible within the limits of my financial resources. After these basic needs are met, I understand that I can stipulate, in writing, how I wish to use the non-prioritized funds as long as my funds are managed in a way that prevents my being abused, neglected and/or exploited by myself or others.

I understand that this agreement becomes effective the day that either the Social Security Administration or the Monterey County Public Guardian appoints the MCHD as my Representative Payee and the MCHD Representative Payee signs this document accepting me as a client of their Representative Payee Services.

Client's Signature	Witness Signature
Date	Date

TO BE COMPLETED WHEN HEALTH DEPARTMENT HAS BEEN DESIGNATED REPRESENTATIVE PAYEE

_____ has been accepted as a Representative Payee client of MCHD as stipulated in

stipulated in the above signed agreement and as governed by the regulations of the Representative Payee Services of the Monterey County Department of Health, Behavioral Health Division, Adult Mental Health Services Program.

Representative Payee or Case Manager Signature	Date

White – Case File Canary – Client

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MONTEREY COUNTY DEPARTMENT OF HEALTH

REPRESENTATIVE PAYEE SERVICES (RPS)

CLIENT'S RIGHTS AND RESPONSIBLITIES

As participant of the Representative Payee Services administered by the Monterey County Department of Health, Behavioral Health Division, Adult Mental Health Services Program, I understand that I have the right:

- ξ To expect that the MCHD Representative Payee will manage my funds to ensure that my current basic needs for food, shelter, utilities, clothing, medical/dental care and personal needs are met within the limits of my financial assets;
- ξ To request that the MCHD Representative Payee use my non-prioritized income and savings as I choose and to expect my reasonable requests to be honored, unless MCHD determines that my request will not allow me to adequately provide for my current and reasonably foreseeable basic needs or places me In a position of being abuse, neglected and/or exploited by myself or others;
- ξ To request from MCHD a monthly statement showing an accounting of the balance remaining in my Representative Payee account;
- ξ To provide MCHD with a written notice of my intention to terminate my voluntary participation in the Representative Payee Services;
- ξ To petition the Social Security Administration to consider termination of Representative Payee based on capability, and to petition for reconsideration of the appointment in the Representative Payee;

I understand my responsibility of reporting to MCHD:

- ξ Any event that will affect the amount of benefits that I receive or my right to benefits;
- ξ Any change in my home/mailing address or telephone number;
- ξ If I become able to work, if I accept a job, or am capable of managing my finances;
- ξ Any change in my mental, physical, or financial situation;
- ξ Any change in my income or property (real property);
- ξ Any change in the number of people living in my home;
- ξ When I receive or use a credit card, other form of credit or loan;
- ξ If someone becomes available to manage my finances for me;
- ξ My failure to cooperate with other agencies that pay or may pay money to me;
- ξ Any change in my marital status;
- ξ When I no longer wish to voluntarily cooperate with all requirements of the Representative Payee Services;
- ξ Any problems with my checks being mailed to me or my creditors;
- ξ If anyone applies for Conservatorship or Guardianship or Representative Payee for my estate or me.

White – Case File Canary – Client

AGREEMENT WITH MCHD FOR REPRESENTATIVE PAYEE SERVICES
MH366 (Rev 11/01)

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 Monterey County Public Guardian 94-6000524 to be my representative payee.

My Right to Appeal

I have the right to appeal SSA's decision. I can appeal the choice of who will be the representative payee. In most cases, I also have the right to appeal the decision that I need a payee. If I appeal, I will have the right to review the evidence in the file and submit new evidence.

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** (5/91) *U.S. Government Printing Office: 1991 — 281-908/40091

Monterey County Public Guardian/Conservator's Office
Accounting Section

Date: _____

RE: _____ Acct.# _____

Received from:

_____

_____

_____ Trans. Code _____

Description:

_____

_____ Amount _____

_____

Funds are ☐ Inventory ☐ Income ☐ Cash ☐ Check Ck # _____

411-426-10/84

MCHD:MH-112

SOCIAL SECURITY NUMBER: _____ DOB: _____

1. Is client able to manage his/her funds? _____ Yes _____ NO. Describe client's inability/ability to manage own funds.

2. What are client's current money management needs?

   Shelter_____
   Utilities_____
   Clothing_____
   Medical/Dental_____
   Personal Needs_____
   Food_____
   Other_____

3. Has client's living situation changed? _____ Yes _____ NO. Please described changes:_____

4. Has client's mental health status changed? _____ Yes _____ NO. Does client have ability to reason properly? Is client Confused/disoriented and/or have impaired judgement? Is client able to communicate with others?_____

5. Describe Alternative Money Management Interventions Attempted. Have the objectives of the previous money management service plan been met? _____ Yes _____NO. If yes, how? If NO, why not?

6. Describe the current money management services plan, including goals and time frames.

7. Person/s capable and interested in being Payee for client. _____ None

   Name:_____ Address:_____

   Name:_____ Address:_____

Case Manager Signature:_____ Date:_____

Unit Supervisor Signature:_____ Date:_____

ANNUAL REVIEW REPRESENTATIVE PAYEE SERVICES BEHAVIORAL HEALTH DIVISION JH/RPS-IASS.1 11/20/01 MH368 (11/01)	CLIENT NAME:_____ PUBLIC GUARDIAN ACCOUNT NUMBER:_____

SOCIAL SECURITY NUMBER:_____ DOB:_____

FINANCIAL DATA:

_____ CLIENT STARTED WORKING: _____, _____
Date of Employment Name of Employer

_____ CLIENT STOPPED WORKING: DATE LAST WORKED_____

_____ STOP PAYMENT REQUEST:

CHECK NUMBER: _____ CHECK PAYABLE TO: _____

DATE OF CHECK: _____ REASON FOR STOP:
_____

AMOUNT OF CHECK: _____

_____ STOP WEEKLY PERSONAL NEEDS AUTOMATIC PAYOUT(S)

_____ STOP OTHER AUTOMATIC(S) _____

_____ CHANGE CHECK DISTRIBUTION: _____ OFFICE PICK UP _____C-MGR _____ MAIL

_____ SAVINGS IS OVER $2,000.00 LIMIT. STOP SSI UNTIL BALANCE IS BELOW LIMIT.

_____ REQUEST SOCIAL SECURITY TO REDUCE SSI/SSA OVERPAYMENT WHITHOLDING:

FROM: AMOUNT _____ TO _____

_____ REQUEST FOR WAIVER, TOTAL AMOUNT OF OVERPAYMENT:_____

START PASS ACCOUNT: AMOUNT PER MONTH_____

APPLICATIONS:

_____ APPLY FOR MEDI-CAL BENEFITS _____ PLEASE APPLY FOR SSI/SSA BENEFITS.

_____ APPLY FOR MEDICARE BENEFITS_____ APPLY FOR _____ BENEFITS

REQUEST FOR INFORMATION:

_____ REQUEST PRINT-OUT OF CLIENT'S ACCOUNT FROM_____ TO _____
Date Date

_____ OTHER REQUEST, PLEASE SPECIFY_____

CASE MANAGER CHANGES:

_____ CAHNGE OF PAYEE/CASE MANAGER: FROM_____ TO _____

_____ TRANSFER OF PAYEE FROM ADULT SERVICES _____ TO: PUBLIC GUARDIAN

_____ EFFECTIVE THIS DATE _____ THE MONTEREY COUNTY PUBLIC GUARDIAN WILL NOT BE THE PAYEE FOR:_____
COMPLETE BLUE PAYEE-OUT FOR BALANCE OF ACCOUNT, PAYABLE TO: SOCIAL SECURITY ADMIN: (VENDOR CODE# 2139; TRANS. CODE #482; PURPOSE – ENTER CLIENTS SOCIAL SECURITY #. CONSERVED FUNDS)

REPRESENTATIVE PAYEE: _____ DATE _____

UNIT SUPERVISOR SIGNATURE _____ DATE_____

INFORMATION UPDATE FORM
BEHAVIORAL HEALTH DIVISION
REPRESENTATIVE PAYEE SERVICES
PS-IU,K:JR/RPS/IU/ 9/27/94 MH368 1/27/04)

CLIENT NANE:_____

PUBLIC GUARDIAN ACCOUNT NUMBER:_____