FAMILY SERVICE OF ROANOKE VALLEY
PERSONAL AFFAIRS MANAGEMENT
REFERRAL FORM

Date Received:________________________________ Referral From:__________________________

Client Information:

Name____ SS#____________________________
Last First Middle

Permanent Address____

Phone Number____

Temporary Address____

Birthday________________ Place of birth (city and state)____________________________

Marital Status__________________ Sex________

Mother's maiden name____

Father's name____

Physician's name____

Do you have a legal guardian?_____yes_____no Power of Attorney? _____yes_____no
If so, please include documentation.

Do you have a job?________yes ________no

If yes, where?____

Do you own any real property? (vehicle, home, etc.)________________________________
Approximate value____

Source of income (SSA,SSI, VA, Pension, etc)______________________________________

Amount of income____

Any bank accounts (where and balance)____

If you have any questions contact Melinda Persinger 540-563-5316 x 3026

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 Family Service of Roanoke Valley 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.

X ______________________ 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)

*U.S. Government Printing Office: 2003—496-507/60662

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

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 control number. We estimate that it will take about 10 minutes to read the instructions, gather the facts, and answer the questions. **SEND THE COMPLETED FORM TO YOUR LOCAL SOCIAL SECURITY OFFICE.** To find the nearest office, call 1-800-772-1213 (TTY 1-800-325-0778). Send only comments on our time estimate above to: SSA,6401 Security Blvd,Baltimore,MD 21235-6401.

In replying, use this address:
SOCIAL SECURITY ADMINISTRATION

TELEPHONE NUMBER (Including Area Code)
( ) -

DATE

SSA CONTACT

IDENTIFYING INFORMATION (SSA Only)
If different from patient

NAME OF WAGE EARNER OR SELF-EMPLOYED PERSON

SOCIAL SECURITY NUMBER
- -

Privacy Act Statement

Sections 205(a) and 205(j), of the Social Security Act, as amended, authorizes us to collect this information. The information is needed to make a determination regarding whether or not the named individual should be paid benefits directly or whether benefits should be paid to a representative payee. The information you furnish on this form is voluntary. However, failure to provide all or part of the information could prevent an accurate and timely decision on the proper payee for benefit receipt purposes.

We rarely use the information you supply for any purpose other than for making a determination on a claim. However, we may use it for the administration and integrity of Social Security 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: (1) to enable a third party or an agency to assist Social Security in establishing rights to Social Security benefits and/or coverage; (2) to comply with Federal laws requiring the release of information from Social Security records (e.g., to the Government Accountability Office and Department of Veteran 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 of Social Security programs.

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. Information from these matching programs can be used to establish or verify a person's eligibility for Federally funded and administered benefit programs and for repayment of payments or delinquent debts under these programs.

A complete list of routine uses for this information is available in Systems of Record Notices 60-0089 and 60-0222. The notices, additional information regarding this form, and information regarding our programs and systems, are available on-line at www.ssa.gov or at your local Social Security office.

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; SSA will NOT pay for this information. 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 that 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.

NAME OF PHYSICIAN/MEDICAL OFFICER (Please print.)	TITLE
ADDRESS (Number and street, City, State, and ZIP Code)	TELEPHONE NUMBER *(Include Area Code)* ( ) -

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. I understand that anyone who knowingly gives a false or misleading statement about a material fact in this information, or causes someone else to do so, commits a crime and may be sent to prison, or may face other penalties, or both.

SIGNATURE OF PHYSICIAN/ MEDICAL OFFICER	DATE

360 Campbell Ave., SW
Roanoke, VA 24016

As representative payee or fiduciary, Family Service of Roanoke Valley/Personal Affairs Management (FSRV/PAM) is appointed by the Social Security Administration or the VA to receive Social Security and/or SSI payments or VA benefits for those individuals who have difficulty in managing their money. As a representative payee or fiduciary, it is the responsibility of FSRV/PAM to pay for the current and foreseeable needs of the client, as well as to report any changes to Social Security or the VA that may affect the client's payments, eligibility for payments or benefits.

Please note the following:

- PAM representatives work **Monday – Friday, 9am-5pm.** If a representative is not available by telephone, you may leave a message in the appropriate voice mail and a return call will be made to you within 24 hours
- PAM representatives **are not available** on week-ends, holidays, and/or after the aforementioned work hours, including emergency situations that may arise (e.g. "running out of money", legal and/or medical issues)
- If you want to meet with the PAM Coordinator, you must make an appointment by calling the front desk and scheduling same. **No walk-ins will be seen without a scheduled appointment**
- You and your PAM representative will make arrangements for disbursement of your money (by mail or arranged pick-up time at Family Service)
- It is your responsibility to make sure Family Service has all of your bills that must be paid. We can only pay bills that we know about! They can be mailed to us (take into account mail time, processing time, and date bill is due, realizing that we mail the bills to be paid) or dropped off at the front desk in a timely manner. The client's account will be responsible for any late fees
- As representative payee, Family Service cannot correct "bad debt" if the client creates a bill he/she cannot afford. We cannot "fix it"! We pay for current and foreseeable needs. Additionally, FSRV does not supplement your income if there is there is a shortage. Clients are expected to live within their prearranged budget.
- Family Service of Roanoke Valley sets up an account for you and pays you and your bills from that account. You are not authorized to write checks and/or withdraw money from this account.
- No physical/verbal disruptions/threats or any kind of disorderly conduct is allowed at Family Service of Roanoke Valley. Should this occur, you will be asked to leave the facility. If you do not leave peaceably, security will be called.

- If you think your concerns are not being addressed you may fill out the complaint form (available at the front desk) *in writing*, and mail, fax, or deliver to Family Service of Roanoke Valley, ATTN: Melinda Persinger. Do not email.
- Your complaint should have your name, address and phone number, and should be signed and dated.
- Upon receipt of the complaint form, the Director will have seven business days to resolve the complaint. If after 7 days you are still dissatisfied the Director's response or proposed action, you can submit a complaint form to the President & CEO of Family Service, following the same procedure as outlined above.

Any failure to comply with these procedures may result in FSRV/PAM discontinuing your representative payee services.