Boston Money Management Program (BMMP)
Description and Referral Process

Bill Payer Clients

Bill Payer Clients receive functional assistance monthly by a trained volunteer who helps clients sort bills, write out checks, negotiate payments, mail checks and cash checks if required. Your client must have a checking account and must provide monthly copies of bank statements to Ethos for audit.

- Step One: Describe services provided by and client obligations to BMMP and obtain their agreement to participate.
- Step Two: Complete Boston Money Management Program Client Referral Form.
- Step Three: Send both completed forms to BMMP via Email, Fax or Mail (see contact information at bottom of page).

Representative Payee Clients

Representative Payee Clients receive direct account management from Ethos/BMMP Staff. Ethos applies to Social Security Administration to become the "organizational representative payee." SSA checks are mailed directly to Ethos/BMMP. Ethos deposits these checks into an account established as Ethos/BMMP. Ethos is mandated to pay rent and basic utilities first. Ethos will then pay out other non-essential bills, and distribute the remaining amount to the client as "personal needs account" (PNA). Ethos maintains control of the account and makes financial decisions for the client ensuring stability in housing through regular rent and utilities payments. Monthly home visit to review spending plan is required.

- Step One: Describe Representative Payee program to your client and obtain their agreement.
- Step Two: Complete Boston Money Management Program Client Referral Form.
- Step Three: Collect as many income and expense documents from client as you can: lease, bank and billing statements.
- Step Four: Complete the Physician's/Medical Officer's Statement of Patient's Capability to Manage Benefits ***with required signature***.
- Step Five: Send ALL completed forms and documents to BMMP via Email, Fax or Mail

EMAIL	FAX	MAIL
dross@ethocare.org Subject: "Referral"	"ATTENTION BMMP" (617) 344-0736	BMMP, Ethos 555 Amory Street Jamaica Plain, MA 02130

CLIENT REFERRAL FORM - Boston Money Management Program

Type of Service Needed: ❒ Bill Payer ❒ Representative Payee

Client Name:__________________________ Date:__________________________

Address:__________________________ Phone:__________________________

Town/Zip Code:__________________________ DOB:__________________________

Mother's Maiden Name:__________________________ Soc Sec#:__________________________

Place of Birth:__________________________ Gender: ❒ Male ❒ Female

Marital Status: ❒ Single ❒ Married ❒ Widowed ❒ Divorced ❒ Domestic Partner

LGBTQ: ❒ Yes ❒ No ❒ Unknown Living Arrangement: ❒ Alone ❒ With (Relationship):______________

Boston Housing Authority Residence?: ❒ Yes ❒ No Female Head of Household? ❒ Yes ❒ No

Ethnicity: ❒ Asian ❒ African American ❒ Hispanic ❒ Caucasian ❒ Other:______________

Non-English Speaking: ❒ Language(s):__________________________

Building Mgr/Landlord:__________________________Phone:__________________________

Emergency Contact:______________Phone:______________Relationship:______________

Family Member Living in New England:__________________________ Relationship:______________

Name of Community Group(s)/Religious Institution(s) you are a member of:__________________________

____

Referring Person:__________________________ Relationship to Client:__________________________

Referring Agency:__________________________ Agency Phone:__________________________

Agency Address:__________________________ Town/Zip Code:__________________________

Referrer Email:__________________________ Referrer Fax: __________________________

MONTHLY INCOME

Soc Sec (SSA): __________________________

SSI/SSDI: __________________________

Other: __________________________

TOTAL: __________________________

Primary Physician (address & phone):____

Please list client's medical conditions:____

____

Does client have memory loss or confusion?:____

Please comment on the condition of the home:____

Does anyone in the client's household smoke?: ❐ Yes ❐ No List Pets:__________________________________

List Agency(s) serving client:____

Agency 1 Contact:____Phone:_________________________

Agency 2 Contact:____Phone:_________________________

How does client pay bills and manage money now?:____

____

Person who now helps client with money management (name & relationship): ____________________________

Reasons for referral (please be specific):____

____

Is the client open to receiving money management help? ❐ Yes ❐ No Prefers: ❐ Male ❐ Female

Is the client at risk of being without food, shelter or utilities? ❐ Yes ❐ No

If so, please state risk and how imminent it is:____

Is client being financially exploited? ❐ Yes ❐ No

If yes, please describe:____

Does this person have excessive amounts of debt? ❐ Yes ❐ No

If yes, please describe:____

There will be a priority matching system based on immediacy of client need, availability of suitable volunteers and vacancies in caseload.

Please complete referral then send with all supporting documents to:	**EMAIL**	**FAX**	**MAIL**
	dross@ethocare.org Subject: "Referral"	"Attention BMMP" (617) 344-0736	BMMP, Ethos 555 Amory Street Jamaica Plain, MA 02130

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 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

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)

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