Boston Money Management Program
(BMMP) Representative Payee
Referral Process

Representative Payee Clients

Ethos will apply to Social Security Administration to become the "organizational representative payee." SSA checks are directly deposited into Ethos/BMMP collective account. Ethos is mandated to pay rent and basic utilities first. Ethos will then pay any other bills the client has as well as personal spending . Ethos maintains the clients account ensuring the clients primary needs are met.

Step One: Complete Boston Money Management Program Client Referral Form.

Step Two: Complete the Physician's/Medical Officer's Statement **(if client doesn't currently have a payee)**

Step Three: Complete and sign the Advanced Notification form.

Step Four: Collect as many income and expense documents from client as you can: lease, bank and billing statements.

Step Five: Send ALL completed forms and documents to BMMP via Email, Fax or Mail

EMAIL
ppierrette@ethocare.org
Subject: "Referral"

MAIL
BMMP, Ethos
555 Amory Street
Jamaica Plain, MA 02130

FAX
"ATTENTION BMMP"
(617) 344-0736

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: $ 0.00

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:_____

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Social Security Administration

TOE 250

Form A
OMB No

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

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.

IDENTIFYING INFORMATION (SSA or
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

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

*U.S. Government Printing Office: 1994 --300-948/00029

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 Ethos BMMP 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.

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** (9-1994) ef (5-2005)
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