# 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 OR BRING THE COMPLETED FORM TO YOUR LOCAL SOCIAL SECURITY OFFICE. You can find your local Social Security office through SSA's website at www.socialsecurity.gov. Offices are also listed under U.S. Government agencies in your telephone directory or you may call Social Security at 1-800-772-1213 (TTY 1-800-325-0778).** ***Send only comments relating to 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, authorize 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.socialsecurity.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<br>- - | 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

| PATIENT'S NAME | | PATIENT'S ADDRESS (Number and Street, City, State, and ZIP Code) |
|---|---|---|
| PATIENT'S SOCIAL SECURITY NUMBER<br>- - | PATIENT'S DATE OF BIRTH | |

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)*<br>( ) - |

**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 |
|---|---|