

S.N.E.S.A.A.

Southern New England Social Assistance Association

**** Step One**** Please contact Kim Santos, S.N.E.S.A.A.'s President, prior to filling out the application.

We look forward to working with you and the individuals you support (age 18+).

Below is the list of forms and documents you will need to fill out and return to S.N.E.S.A.A., via fax or email, so that we can be assigned as a Representative Payee.

Documents to be Submitted:

1. Advance Notification of Representative Payment
2. Client Contract
3. Client I.D. Sheet
4. Client Work Information
5. Authorization for Release of Information Form
6. Lay Person Letter (directions are included in this packet)
7. Most Recent Rental/Room & Board Agreement or Lease or Charges for Care Letter (include client address on agreement)
8. Certified Appointment of Guardian Decree. All new referrals with a legal guardian will need to submit a **Certified Appointment of Guardian Decree with raised seal** via MAIL to S.N.E.S.A.A. This is an S.S.A. requirement. Copies are not acceptable. Suggestions to Obtain Certified Appointment of Guardianship Decree are included in this packet.
9. S.S.A. Form 787, Medical Source Opinion of Patient's Capability to Manage Benefits. This form is **required if client does not currently have a Representative Payee.** Forms are available online www.snesaa.org/forms

Please note:

- **Documentation Requirements** are detailed on the last two pages of this packet. As a suggestion, you may want to post these in your office as a quick reference.

If you have any questions please e-mail me at info@snesaa.org

Sincerely,

Kim A. Santos

Kim A. Santos
President

Southern New England Social Assistance Association (S.N.E.S.A.A.)
P.O. Box 0409
Swansea, MA 02777
Phone: 774-365-4441 **Fax:** 774-365-4442
info@snesaa.org www.snesaa.org

Advance Notification of Representative Payment

Name of Wage Earner, Self-employed person or
S.S.I. claimant

Social Security number

Name of Beneficiary (if other than above)

Relationship to Wage
Earner, Self-Employed
Person or S.S.I. Claimant

I understand and agree with the following:

Need for Representative Payee

The Social Security Administration (S.S.A.) has decided that I need someone to manage my Benefits. Because of this, S.S.A. 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

S.S.A. has selected Southern New England Social Assistance Association (S.N.E.S.A.A.) to be my representative payee.

My Right to Appeal

I understand that I have the right to appeal S.S.A.'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 S.S.A. 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)

Client Name: _____

Agreement:

I, or my advocate, have discussed my needs with a S.N.E.S.A.A. representative. I agree to have S.N.E.S.A.A. serve as my representative payee for my monthly R.S.D.I., S.S.D.I., S.S.I. or S.S.P. benefits in return for a fee charged at/or below Social Security Administration's regulated rate.

I understand that S.N.E.S.A.A. will provide the following services:

- Deposit, monitor and review all federal benefits received
- Ensure compliance with Federally mandated S.S.A. regulations
- Develop budget plans to meet my financial goals
- Process payments and store records of my expenses
- Maintain up-to-date records with the S.S.A.
- Provide annual reporting to S.S.A.
- Upon request issue reports outlining account activity and balances

S.N.E.S.A.A. will be responsible for the timely payment of the following:

Amount	Category	Payable To	Mailing Address
\$	Rent		
\$	Personal		
\$	Phone		
\$	Electric		
\$	Gas		
\$	Cable		
\$	Other		

I agree to:

- Pay S.N.E.S.A.A.'s monthly fee
- Treat S.N.E.S.A.A.'s staff with courtesy and respect
- Submit most recent rental agreement/room & board agreement/lease or charges for care letter
- Submit pay stubs per pay period (if applicable)
- Submit bank statement monthly (if applicable)
- Submit a Move Form when necessary – prior to actual move date
- Submit receipts when required

I understand that if I fail to comply with these rules, S.N.E.S.A.A. may refuse to continue to serve as my representative payee.

 Beneficiary/Guardian Signature Date: _____

 Witness Signature Date: _____

Client Name: _____

Client Information:

Client Name: _____ Social Security #: _____

Living Address: _____ Gender: M ___ F ___ Other ___

Phone #: _____

Move in Date: _____ Date of Birth: _____

Housing Type: (please check one and complete necessary information on same line)

Adult Family Care Name of Provider: _____

Shared Living Name of Provider: _____

Group Home # of Other Individuals Living with Client: _____

With Someone Else Name and Relationship: _____

Alone

Other..... Please Describe: _____

Guardian Information: *Please Mail a Certified Appointment of Guardian Decree with Raised Seal*

Guardian Name: _____

Address: _____

Phone #: _____

Email: _____

Client Name: _____

Current Representative Payee:

Name: _____ **Phone:** _____

Address: _____

Bank Name: _____ **Balance: \$** _____ **Date:** _____

Additional Information for Annual S.S.A. Report:

Married? Yes No **Divorced:** Yes No **Widower:** Yes No

Number of Children: _____

Military or Rail Road service? Yes _____ No _____

Have You Traveled Outside Of The US For More Than One Month? Yes _____ No _____

Have You Ever Used Another Name Or SS#? Yes _____ No _____

If yes, please note other name or SS#: _____

Client Birth Place: _____

Mother's Maiden Name: _____

Are You Legally Blind? Yes _____ No _____ *If yes, please submit a copy of the Doctor's order or MCB Certificate.*

Are You A U.S. Citizen? Yes _____ No _____

If not, what country are you a citizen of? _____

Are You Currently Receiving Workmen's Comp or Unemployment? Yes _____ No _____

Are You, Or Have You Ever Been, Incarcerated/Parole/Probation? Yes _____ No _____

If yes, where and when? _____

Was it a felony charge? Yes _____ No _____

If it was a felony charge where and when? _____

Are there any federal/state warrants or any type of parole or probation violations? Yes _____ No _____

If yes, where and when? _____

Please list all Health Insurance Providers (Including Medicare & Medicaid):

Client Name: _____

Client Financial Information:

Income:

How much do you receive for each monthly benefit or work? *Please fill in all that apply.*

R.S.D.I. \$ _____ S.S.D.I. \$ _____ S.S.I. \$ _____ S.S.P. \$ _____

Annuity \$ _____ Food Stamps: Yes No

Bank: *If none please write "NONE." Do not include Representative Payee Accounts.*

Savings Bank Name: _____ Most Recent Balance: \$ _____ Date: _____ Last 4 digits of account #: _____

Checking Bank Name: _____ Most Recent Balance: \$ _____ Date: _____ Last 4 digits of account #: _____

*Need copy of most recent bank statement for savings and/or checking account if applicable.

Assets:

List Assets (Stocks, Bonds, 401k, own Car, own Property, Life Ins., Trusts, Pre-Paid Burials - if none, please write "NONE"):

** Please include most recent documentation that includes the value of the above asset.

Authorized Agency Contacts:

State Agency:

Address: _____ City/State/Zip: _____

Contact Name: _____ Phone #: _____

Email: _____

Residential/Support Agency:

Address: _____ City/State/Zip: _____

Contact Name: _____ Phone #: _____

Email: _____

Client Name: _____

Please notify S.N.E.S.A.A. when a Client starts and/or stops working because it can directly affect their benefits.

Client Work Information:

PLEASE NOTE: All Pay Stubs must be submitted to S.N.E.S.A.A. per pay period in order for S.N.E.S.A.A. to report client's earnings to S.S.A.

This can be done by:

- Faxing or emailing pay stubs to S.N.E.S.A.A.
- Having the payroll department fax or email a monthly gross wage report to S.N.E.S.A.A.

Please check box if client has never worked:

Client Name: _____

Employer Name: _____

Employer Address: _____

Phone #: _____

Supervisor's Name: _____

Start Date: _____

Weekly # Hours: _____

Hourly/Piece Rate: _____

Avg. Gross Weekly Pay: \$ _____

Client Stopped Working Information:

Employer Name: _____ **End Date:** _____

Is the Client receiving worker's compensation benefits? Yes No

If yes, Date Started: _____

Is the Client receiving unemployment benefits? Yes No

Amount Receiving: _____

Agency/Organization Information:

Name: _____
 Address: _____

 Phone: _____
 Contact Person: _____

Client Information:

Name: _____
 Address: _____

 Phone: _____

[] I hereby authorize the provider or agency named above to release the following information to Southern New England Social Assistance Association (S.N.E.S.A.A.).

[] I hereby authorize Southern New England Social Assistance Association (S.N.E.S.A.A.) the right to request a change of address forms for the following types of Accounts Payable and Documentation:

- | | | |
|--|--|---|
| <input type="checkbox"/> Bank Records | <input type="checkbox"/> Medical Bills | <input type="checkbox"/> Legal |
| <input type="checkbox"/> Utility Bills | <input type="checkbox"/> Credit Card | <input type="checkbox"/> Court Documents |
| <input type="checkbox"/> Tuition | <input type="checkbox"/> Insurance | <input type="checkbox"/> Other (Specify eg. Verizon, Cox, Attorney) |

Purpose of use or disclosure of information
 (for example: Medical Care, Legal, Insurance,
 Personal, Individual's request, etc. Must be specific. _____

I understand that I have a right to revoke the authorization at any time. If I revoke this authorization, I must do so in writing and present it to the person/facility/agency that was authorized to release the information. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that once the above information is disclosed, the recipient may re-disclose it and the information may not be protected by federal or state privacy laws or regulations. I understand that authorizing the use or disclosure of the information identified above is voluntary and that this authorization to release my information is considered active while S.N.E.S.A.A. remains my Representative Payee. I understand that I do not need to sign this form to continue to receive Representative Payee services from S.N.E.S.A.A.

 Beneficiary/Guardian Signature Date _____

 Witness Signature Date _____

Lay Person Letter Directions

All new client referral packets submitted to S.N.E.S.A.A. need to include a Lay Person Letter. This letter is a requirement by the S.S.A.

- A **Lay Person Letter** is a letter by you on your organization/company letterhead that states your relationship to the Client and why in your opinion they still need a Representative Payee (e.g. it could be because they cannot prioritize bills or do not have an understanding of money due to their disabilities).
- You may want to include the client diagnosis to support the above statement.
- Please also include why the current Representative Payee will no longer be serving as the payee.

If you have any questions please feel free to contact

Kim Santos at 774-365-4441 or via email snesaa@yahoo.com.

Suggestions to Obtain a Certified Appointment of Guardian Decree

New Social Security Requirement: All new referrals with a legal guardian, will need to submit a Certified Appointment of Guardian Decree with raised seal via MAIL to S.N.E.S.A.A.'s P.O. Box.

- Check with the Guardian - They may have the document.
- There may be one in the client's records your agency maintains.
- Contact the Trial Court/Probate & Family Court from the County it was issued (this information is typically in the right top corner of the decree). Ask the court how to obtain a certified Appointment of Guardian Decree (with raised seal). Please note there it typically a fee for these documents.
- It's been our experience that fees can possibly be waived when requests are made on your agency letterhead.

If you have any questions please feel free to contact Kim Santos at 774-365-4441 or via email snesaa@yahoo.com.

Documentation Requirements

(Needed in order to stay within compliance of S.S.A. regulations)

- **Bank Statements:**

Submit Monthly

(cross out all but the last four digits of the account number)

- **Pay stubs:**

Submit Per Pay Period

- **Spend-downs:**

Submit Monthly as Needed

- **Moves:**

Notify Immediately

Submit Move Forms to snesaa@yahoo.com

Move Forms are available online www.snesaa.org/forms

- **Hospitalizations:**

Notify Immediately

See Best Practices Documentation Template for timeline and information to be submitted. www.snesaa.org/forms

Client Bank Accounts:

- Client's account at S.N.E.S.A.A. should remain at \$1000 or less
- Client's personal savings or checking accounts should remain at \$300 or less

Check Request:

- Located on our web site at www.snesaa.org/forms
- Generates a one-time check
- Fill in completely in order for processing
- **Cash within 30 days**
- All receipts to be submitted within 60 days or if another one time check request is needed then past receipts need to be submitted
- Examples: Check stub with all receipts / full name with receipts and check amount (faxed or emailed)
- Attestation Letter to be submitted for lost receipts (directions can be found online www.snesaa.org/forms)
- Receipts DO NOT need to be submitted for automatic recurring monthly and/or weekly personal checks

Moves: Move Forms can be found online www.snesaa.org/forms

- Move in date
- Type of living arrangement (group home, AFC, alone, shared living...)
- New address
- New phone number
- Stop any previous rent/ personal payments
- New rental agreement
- New contacts and contact info (names, #'s, Agency...)