

Canton Payee
601 Cleveland Avenue NW
Canton, Ohio 44702
Phone: 330.453.4275
Fax: 234.425.5601

Hours of Operation

Walk-up Window Hours:

Monday and Wednesday 9:00am - 12:00pm; Closed Tuesday, Thursday & Friday

Phone Hours:

Monday, Wednesday & Friday: 10:00am - 2:00pm; Closed Tuesday & Thursday

Who receives Payee Services?

We provide payee services to individuals who are required to have a payee to manage their Social Security benefits, Pension checks, or Veteran's benefits.

What is a Payee Service?

We receive your monthly benefits and must use the money to pay for your current needs, including:

- Housing
- Utilities
- Food
- Medical and Dental expenses
- Personal care items
- Clothing; and
- Rehabilitation expenses (if you are disabled)

After the above expenses are paid, we can use the rest of the money to:

- pay any past-due bills you may have
- give you spending money
- support your dependents
- provide funds for entertainment

If there is money left over we will save it for you. We are required to keep accurate records of your money and how it is spent. We also regularly report the information to Social Security and the Veterans Administration.

Benefits of Our Payee Service

- We can contact Social Security directly for prompt answers to questions
- Rent and utilities paid on time
- Monthly budget personalized to your needs
- Convenient access to your funds through a debit card.
- Located on the SARTA bus line

Payee Costs

We charge \$57.00 per month for payee services. This money is withdrawn from your account monthly. If you are currently receiving case management services through the StarkMHAR, live in Stark County and receive less than \$1,014 in benefits per month we are able to bill the StarkMHAR for your fee. If you are currently receiving services from the Stark County Board of Developmental Disabilities and have been assigned an SSA we are able to bill the Stark County Board of Developmental Disabilities for your fee.

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Application for Payeeship

Please Print:

Full Name: _____ Today's Date: _____

Social Security Number: _____ - _____ - _____

Date of Birth: _____ City of Birth: _____

Street Address: _____

City: _____ Zip: _____

How long have you lived at the above address? _____

Home Phone: _____ Cell Phone: _____

Mother's Maiden Name: _____

Case Manager: _____ Agency _____

Case Manager Phone: _____

Current Landlord: _____ Landlord Phone: _____

Monthly Rent Amount: _____

Any **past** due rent? ☐ Yes ☐ No

If yes, Amount owed: \$ _____

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Please check type of housing:

- ☐ Alone
☐ Group home
☐ With family members; Names of all household members and relationship to you:

- ☐ With friends; Names of all household members:

- ☐ Other Please describe:

Type of Monthly Benefits Received:

- ☐ Social Security Disability; Amount: \$ _____
☐ Social Security Insurance; Amount: \$ _____
☐ Pension Amount: \$ _____ Name of Company: _____
☐ Veteran Administration; Amount: \$ _____

Emergency Contact Name: _____

Relationship to you: _____ Phone: _____

Next of Kin Name: _____

Relationship to you: _____ Phone: _____

Guardian Name: _____ **Guardian Phone:** _____

Address: _____ Dated: _____

****Must provide guardian paperwork with Application***

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List the names and relationship of any relatives or friends who show active interest with the applicant:

Name: _____ Phone: _____

Address: _____

Relationship: _____

Describe type and amount of support and/or how interest is displayed:

Name: _____ Phone: _____

Address: _____

Relationship: _____

Describe type and amount of support and/or how interest is displayed:

Other Notes:

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 Canton Payee Center 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 my 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.

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Signature

Date

Witnesses are required only if this statement has been signed by (x) above. If signed by mark (x) witnesses to the signing who know the person making the statement must sign below, giving their full addresses.

Signature of Witness

Signature of Witness

Address (Number and Street, City, State and Zip Code)

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LIMIT OF LIABILITY AGREEMENT

The Canton Payee (CP) program acting as representative payee for _____ (client) does hereby agree to follow guidelines set forth by the Social Security Administration (SSA) in the distribution of funds by a representative payee.

The SSA requires that housing and nutritional needs be met prior to disbursing funds for any other debts. As this is the case, the CP will issue payment on rents or mortgage and utilities as a priority; then funds for grocery, spending and tobacco will be available through a debit card.

The Canton Payee will be glad to assist in payment of any debts including but not limited to credit debts, fines and insurance premiums, working within the confines of the monthly income of each individual client. It should be noted that these items are not priority and that the client is responsible for these debts. Should the Canton Payee be unable to meet these expenses, the Canton Payee is not liable for any resulting consequences such as collection attempts, arrests or warrants for non-payment of fines, or cancellation of services.

Again, the Canton Payee is responsible for payment of any expenses only to the extent of monies received in our office.

I have read the above statement of liability and/or it has been explained to me in full. I understand the limit of liability herein described and acknowledge my acceptance of the terms referenced.

Client Name (printed)

Client Signature

Date

CP Staff Signature

Date

Medical Source Opinion of Patient's Capability to Manage Benefits

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

YOUR HELP IS NEEDED

The patient shown above has filed for or is receiving Social Security or Supplemental Security Income benefits. We need you to complete the remainder 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 they need a representative payee to manage the Social Security Administration (SSA) benefits on their behalf.

Please Note: This determination affects how benefits are paid and has no bearing on disability determinations. Unfortunately, SSA cannot compensate you for the time it takes to provide this information. Thank you for your help.

WHAT IS A REPRESENTATIVE PAYEE

A representative payee is someone who manages the patient's SSA benefits to make sure the patient's basic 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 managing their SSA benefits or directing others to manage them to meet their basic needs, so we select a representative payee to receive their benefits on their behalf. Examples of impairments that may cause incapability are dementia, brain damage or chronic schizophrenia. However, a person's need for some assistance with financial tasks, such as bill paying, does not necessarily mean they cannot make decisions concerning basic needs and are incapable of managing their own benefits. If the individual is able to direct the management of their own benefits, then we will consider the individual capable.

PLEASE COMPLETE THE INFORMATION ON THE REVERSE OF THIS FORM

PATIENT'S NAME

PATIENT'S SOCIAL SECURITY NUMBER

PATIENT'S DATE OF BIRTH

PATIENT'S ADDRESS (Number and Street, City, State, and ZIP Code)

1. Date you first saw the patient _____

2. Date you last saw the patient _____

3. How many times have you seen this patient? _____

4. Are you able to assess the patient's ability to manage or direct the management of funds? ☐ Yes ☐ No

If no, please skip the remaining questions and date the form.

5. What is the basis for your assessment (e.g. observation, medical records, diagnostic tests, patient's self-report, family member's report)?

Note: Please keep in mind in responding to the following questions that the actual performance of the patient, when known, is usually the best indicator of the patient's abilities.

6. Does the patient:

- Have a general understanding of their finances (i.e., income, assets, expenses)? ☐ Yes ☐ No ☐ Unknown
- Have sufficient ability to handle a checking/savings account? ☐ Yes ☐ No ☐ Unknown
- Have sufficient ability to pay bills in a timely manner? ☐ Yes ☐ No ☐ Unknown

7. Can the patient successfully manage or direct the management of funds to meet basic needs (e.g. food, clothing, shelter)?

☐ Yes

If "Yes," please provide a brief summary of the findings that led to this conclusion, and complete question 8. Please date the form.

☐ No

If "No," please provide a brief summary of the findings that led to this conclusion, and complete question 8. Please date the form.

☐ Unsure

If "Unsure," please explain and date the form.

PLEASE COMPLETE THE INFORMATION ON PAGE 3

8. Do you expect the patient to be able to manage or direct the management of their benefits in the future (e.g. the patient is temporarily unconscious)?

☐ Yes ☐ No

Please explain your answer.

NAME OF MEDICAL SOURCE (Please print)

TITLE

ADDRESS (Number and Street, City, State, and ZIP Code)

TELEPHONE NUMBER (Include Area Code)

DATE

Privacy Act Statement Collection and Use of Personal Information

Sections 205, 807 and 1631(a) of the Social Security Act, as amended, allow us to collect this information, which we will use to determine the beneficiary's need for a representative payee. Providing the information is voluntary, but not providing all or part of the information may prevent us from making a determination regarding the beneficiary's capability or inability to handle their own benefits. As law permits, we may use and share the information you submit, including with other Federal agencies, contractors, and others, as outlined in the routine uses within System of Records Notices (SORN) 60-0089 and 60-0222, available at www.ssa.gov/privacy. The information you submit may also be used in computer matching programs to establish or verify eligibility for Federal benefit programs and to recoup debts under these programs.

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 20 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)**. You may send comments on our time estimate above to: SSA, 6401 Security Blvd, Baltimore, MD 21235-6401. **Send only comments relating to our time estimate to this address, not the completed form.**