RCAL REPRESENTATIVE PAYEE
at Resource Center for Accessible Living Inc

727 Ulster Avenue, Kingston, NY 12401 | www.rcal.org
TEL: 845.331-7039
FAX: 845.331.2076
reppayee@rcal.org

Enclosed please find out Representative Payee packet. Included are:

- Representative Payee Application (pages 2 & 3)
- Release of Information Form (page 4 & 5)
  (required because we are an Independent Living Center)
- RCAL Consumer Rights and Responsibilities form (pages 6 & 7)
- Social Security Employment Notification for Rep Payee Individuals & Instruction sheet (pages 8 & 9)
- Representative Payee Acknowledgement (page 10)
- SSA-827 Authorization to Disclose Information (pages 11 & 12)
- SSA-787 Physician's Statement (pages 13, 14 & 15)
- Release of information NYSED ACCES & signature (pages 16 & 17)
- Initial Budget Meeting List (page 18)

Once these forms are completed, please bring or mail them along with letters from any other parties who may have information about your need for a Representative Payee to RCAL. RCAL will complete the SSA-11 to request to be your Representative Payee. After we request to be made Representative Payee, it can be several months before we are appointed your payee by Social Security.

When RCAL is appointed as your Representative Payee, we will schedule a meeting to create a budget with you in order to meet your needs each month. Please see the attached *Initial Budget Meeting List* for what to bring to the appointment.

If you have any questions, please call the RCAL Representative Payee department at **845-331-7039** or email us at **reppayee@rcal.org**.

Thank you!

The RCAL Representative Payee Department

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Representative Payee Application

First Name	Last Name	Social Security Number
Street Address		City
State	Zip code	Telephone

1. What is your date of birth?
2. What is your gender? ☐ Female ☐ Male
3. What is your primary disability?
4. What city were you born in?
5. What is your mother's Maiden name?
6. What level of education have you completed?

☐ PreK Program	☐ GED Diploma
☐ K-8	☐ IEP Diploma
☐ Some High School	☐ Completed 2yr Undergrad Degree
☐ Completed High School	☐ Completed 4yr Undergrad Degree
☐ Some College	☐ Completed Post Graduate Degree
☐ Business Trade, Vocational School	

7. Are you a veteran? ☐ Yes ☐ No
8. What is your race/ethnicity?

☐ White	☐ Asian
☐ African American (non-Hispanic)	☐ Hispanic/ Latino
☐ Native American or Alaskan Native	☐ Native Hawaiian or Pacific Islands
☐ 2 or more races	☐ Unknown

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Representative Payee Application continued

9. What is your current employment status?

☐ Full Time
☐ Part Time
☐ Looking for a job
☐ Unemployed (not looking)
☐ Student or in a program
☐ Retired
☐ Participating in segregated work or day program
☐ Other employment program not specified

10. Which best describes where you live?

☐ Alone
☐ In my home
☐ With a relative
☐ With someone else
☐ In a public institution
☐ In a private institution
☐ In a Nursing home
☐ In a board and care facility

11. Do you pay rent? ☐ Yes. ☐ No. If yes, what is your rent? $_____

Bank Name	Account type (Checking/Savings)
Bank Name	Account type (Checking/Savings)

12. Do you have a life insurance policy? ☐ Yes. ☐ No. If yes, list below:

Insurance Company	Policy Type (Term Life/ Whole Life)

13. Do you own a burial plot? ☐ Yes. ☐ No.

14. Do you have Medicare? ☐ Yes. ☐ No. Medicaid? ☐ Yes. ☐ No.

15. If you have Medicaid, do you have a spend-down? ☐ Yes ☐ No. If yes, what amount? $_____

16. Do you receive SNAP benefits? ☐ Yes ☐ No.

17. What other types of benefit do you receive? ☐ SSI. ☐ SSDI. ☐ Retirement. ☐ Other:

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AUTHORIZATION FOR RELEASE OF INFORMATION

RE: Name			Social Security Number
Parent or Guardian's Name			Date of Birth
Address	City	State	Zip

I hereby authorize and request Resource Center for Accessible Living (RCAL) to: (please check one or both)

Release to ☒ Obtain From ☒

☐ Access VR	☒ MHA of Ulster County	☐ ARC Dutchess County	☐ MHA of Dutchess
☐ Devereaux	☒ Gateway Industries	☒ Social Security Admin	☒ RUPCO
☒ DSS	☒ Ulster G-ARC	☐ Taconic DDSO	☒ Kingston Housing Auth

Other	Phone
Other	Phone
Other	Phone
Other	Phone

THE FOLLOWING SPECIFIC INFORMATION

Specific information to be released BY:

RCAL

☐ All RCAL Records
☐ Intake
☐ ISP/ Narrative / IL Plan
☐ Documentation of disability
☐ Case notes
☒ Information related to Representative Payee
☐ Other

Specific dates:

Specific information to be released TO:

RCAL *(This information may include mental health or alcohol or drug abuse records).*

☐ All Records
☐ SSI / SSDI information
☐ Social History
☐ Alcohol / Drug Assessment
☐ Discharge Summary
☐ Psychological Evaluation
☐ Psychiatric Evaluation
☐ Legal information
☐ Work record
☐ Medical Records
☒ Information related to Representative Payee
☐ Other_____

Information to be released in: ☒Verbal form ☒Written form

The purpose for this disclosure is: (check all that apply)

☐ Documentation of Disability | ☐ Coordination of Services | ☐ Benefits Counseling | ☐ Legal
☒ Representative Payee Coordination | ☐ Other _____

I understand that this consent is revocable at any time prior to the release of this information. This authorization will expire twelve (12) months from the date below or thirty (30) days after termination of services, whichever is sooner. A person has the right to access information generated by ***RCAL***. Copies of the records may be obtained with reasonable notice and may involve a minimal copying cost.

Signature:	Date:

If signed by an authorized representative, state relationship and authority.

RCAL authorized Signature

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Release of information continued

Contact Information: (This includes any agencies you are currently working with and/or any friends of family you would like RCAL to have contact with. Please add these individuals or agencies to RCAL 's Release of Information form.)

Name	Relationship/Agency Name	
Street Address	City	
State	Zip	Contact Telephone
Name	Relationship/Agency Name	
Street Address	City	
State	Zip	Contact Telephone
Name	Relationship/Agency Name	
Street Address	City	
State	Zip	Contact Telephone
Print Applicant Name		
Signature		Date:

For office use only

Date Received	SSA-BK-1 I Complete

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Resource Center for Accessible Living Consumer Rights

While you are participating in services offered by the Resource Center for Accessible Living, Inc. (**RCAL**), you have certain rights regarding information relevant to your situation. Your rights include the expectation of confidentiality, use of appropriate releases, access to your file, and conflict of interest free provision of services.

Confidentiality — It is the policy of **RCAL** that any information about anyone applyin.9 for services, or admitted and receiving services, is to be held in confidence (i.e., **RCAL** staff/interns/trainees will not discuss any information about or with anyone outside of **RCAL** (unless assisting you with applying for agency external agency services i.e. Medicaid, Social Security, OPWDD). The only exception is the Executive Director or assignee sharing information when there is a good faith belief that there is an extreme safety issue (example: possible harm to yourself or others).

Release of Information — Any information obtained or to be disclosed is to be done with the understanding that the information will be confidential and is to be maintained exclusively for the purpose of planning and provision of services. Permission to obtain or release information must be in writing. The release is ongoing for one year, unless termination is requested by you in writing.

Access to Files — You have a right to look at your file. **RCAL** requests you make an appointment to look at your file at least 48 hours in advance. You may add to or delete information from your record. Due to regulations and legal responsibilities, **RCAL** may only produce records originally generated by **RCAL**. Your advocate may assist you in obtaining original information from other sources if requested. However, original records from another source that you provided to **RCAL** would be available to you when you access your file. These original records would have been marked as originals upon receipt at **RCAL**.

Conflict of Interest Free Provision of Services — As the local independent living center promoting choice and independence

Resource Center for Accessible Living Consumer Responsibilities

RCAL will provide you with programs and resources to support you regardless of race disability, age, religion, ethnicity, military status, domestic violence victim status, marital status, gender, sexual orientation, gender identity, or economic status in a respectful and professional manner. RCAL will work with you collaboratively to obtain your stated goals as long as you are working cooperatively on the objectives. As **RCAL** is a consumer-directed agency, your role in exerting independence is integral to the joint effort required to meet your independent living goals and objectives. As a consumer you play an integral role in acquiring services at **RCAL** because our services are consumer-directed in nature. Therefore, you are responsible for:

- Participating in efforts to exert independence
- Respecting all members of **RCAL**, including staff, other consumers, and visitors
- Providing, to the best of your knowledge, accurate and complete information about your current state of health and wellness as it applies to receiving supports through **RCAL** that will help you to become more independent.
- Reporting unexpected changes in your condition that may affect how we assist you, to the responsible Independent Living Advocate
- Communicating whether you clearly understand the scope of available services and what is expected of you.

Keeping your appointments and notifying **RCAL** staff when you are unable to do so. To cancel or reschedule an appointment with an Independent Living Advocate, call (845) 331-0541.

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Consumer Standards of Conduct:

Consumers shall not:

- Engage in any behaviors that constitute abuse: physical, verbal, financial, or emotional to another person.
- Possess dangerous materials, weapons such as firearms, knives, or explosives while on RCAL property, or with RCAL staff, visitors. or associates offsite.
- Engage in criminal conduct including disorderly or obscene conduct while on RCAL property (vandalism, stealing, selling drugs, fighting or threatening violence)
- Smoke on the premises including the parking lot.
- Disregard direction from RCAL staff, volunteers, or associates as it pertains to safety issues.
- Consume alcohol or illegal drugs on the property including the parking lot or come in the building or parking lot intoxicated or high persons who appear to be obviously intoxicated or high may not be allowed access to staff or services.

Grievance Procedure:

If you are not fully satisfied with your experience at RCAL, consumers may use the following methods to address concerns regarding services provided: If you are not fully satisfied with your experience at RCAL, consumers may use the following methods to address concerns regarding services provided:

1. Upon receipt of your written request to the Chief Operating Officer, you may request, without prejudice, another Independent Living Advocate. This Advocate will be assigned to you within 5 business days of receipt and will remain the sole coordinator for the services you request.
2.
   a. If you are unsatisfied with the service, you may first request in writing a meeting with your Independent Living Advocate; you may also request that their Supervisor be present to hear your concerns. This meeting will be scheduled at your earliest convenience within two weeks of receipt of your letter.
   b. Should you still be unsatisfied, after the initial meeting, with the service, you may request to speak to the Compliance Officer, call (845) 331-0541, extension 16. Upon receipt of a phone call the Compliance Officer will return your call within 3 business days.
   c. You may request to speak to the Executive Director, if you remain unsatisfied with the service. Upon Receipt of your phone call the Executive Director will return your call within 3 business days or as soon as possible if the Executive Director is out of the office.
3. You may choose to bypass these options and directly contact ACCES-VR offices at:

   Rookmini Mangal MSEd., CRC, Vocational Rehabilitation Counselor NYS Education Department
   89 Washington Avenue, Albany, NY 12234
   P: (518) 486-3777 F: (518) 473-6073

Consumer Signature	Date
Print Consumer Name	Staff Signature

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Wage Notification Instruction Sheet

As an individual who receives benefits from Social Security, you are required to report your wages each month to Social Security. As your Representative Payee, this is a service that RCAL may provide. Please see the attached information sheet.

If you choose RCAL to provide notification to Social Security:

1. Complete the Social Security Employment Notification for Representative Payee Individuals form indicating that you would like RCAL to notify Social Security and return it to RCAL.
2. Provide RCAL with copies of your pay stubs by the last week of each month.

If you choose to notify Social Security of your wages:

1. Complete the Social Security Employment Notification for Representative Payee Individuals form indicating that you would like to notify Social Security of your wages and return it to RCAL.
2. Notify Social Security in the following ways by the 10th of the month following the month worked. To find out how to go about reporting your wages please call your local Social Security office at 1-877-405-6747. They have several different options available for wage reporting.

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Social Security Employment Notification for Representative Payee Individuals

RE:

Date

As the Representative Payee, Social Security requires that the Resource Center for Accessible Living, Inc. (RCAL) provide them with a monthly report of the wages earned by persons receiving Social Security funds. Below please provide us with information regarding your employment. You may choose to provide notification to Social Security yourself. If that is the case, please indicate that below.

Please be aware that FAILURE TO NOTIFY SOCIAL SECURITY of your income could result in TERMINATION OF YOUR BENEFITS.

Name of Employer

Date Employed

Hours scheduled per week

Hourly wage $

PAID ☐ Weekly ☐ Biweekly ☐ Bimonthly ☐ Monthly

Please choose one

- I authorize RCAL to notify Social Security of my monthly wages. I will provide RCAL with paystubs by no later than the last week of each month.
- I DO NOT authorize RCAL to notify Social Security of my monthly wages. I will notify Social Security myself. I understand that FAILURE TO NOTIFY SOCIAL SECURITY of my income could result in TERMINATION OF MY BENEFITS.

Signature

Signature of RCAL Representative

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Representative Payee Acknowledgement

I understand that by signing and submitting these documents I am acknowledging that I am requesting that RCAL be appointed as my representative payee. I further authorize RCAL to submit the SSA-BK-11 form on my behalf to The Social Security Administration (SSA) in order to have RCAL appointed as my representative payee.

Print Applicant Name	
Client Signature	Date
RCAL Staff Signature	Date

Social Security Administration

Form Approved
OMB No. 0960-0024

PHYSICIAN'S/MEDICAL OFFICER'S STATEMENT 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 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 SOCIAL SECURITY NUMBER	PATIENT'S DATE OF BIRTH

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

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
If "Yes", please omit question 3, but be sure to sign and date the form.

☐ No
If "No", please provide a brief summary of the findings that led to this conclusion. Also, complete question 3.

☐ Unsure
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*)

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 statement about a material fact in this information, or causes someone else to do so, commits a crime and may be subject to a fine or imprisonment.

SIGNATURE OF PHYSICIAN/MEDICAL OFFICER	DATE

Privacy Act Statement
Collection and Use of Personal Information

Sections 205(a) and 205(j) of the Social Security Act, as amended, authorize us to collect this information. We will use the information you provide to make a determination regarding the beneficiary's need for a representative payee.

Furnishing us this information is voluntary. However, failing to provide us with all or part of the information may prevent an accurate and timely decision on any claim filed.

We rarely use the information you supply us for any purpose other than to make a determination regarding management of benefits. However, we may use the information for the administration of our programs including sharing information:

1. To comply with Federal laws requiring the release of information form our records (e.g., to the Government Accountability Office and Department of Veterans Affairs); and,

2. To facilitate statistical research, audit, or investigative activities necessary to ensure the integrity and improvement of our programs (e.g., to the Bureau of the Census and to private entities under contract with us).

A list of when we may share your information with others, called routine uses, is available in our Privacy Act System of Records Notices 60-0089, entitled Claims Folders Systems; and, 60-0222, entitled Master Representative Payee File. Additional information about these and other system of records notices and our programs is available online at www.socialsecurity.gov or at your local Social Security office.

We may also use the information you provide in our 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 or administered benefit programs and for repayment of incorrect payments or delinquent 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 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).** *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.***

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Release of Information (AUTHORIZATION PERTAINING TO NYSED ACCES)

Consumer Name	Date of Birth

By signing this form, you authorize Resource Center for Accessible Living, Inc. (RCAL) to allow the review of your consumer file and protected health information by the New York State Education Department's Office of Adult Career and Continuing Education Services.

As an Independent Living Center (ILC), our agency receives funding through NYSED ACCES. NYSED ACCES has the obligation to monitor that our services meet certain eligibility criteria and standards pursuant to state and Federal law. The information reviewed will only be used for the pu1poses, set forth below, and will only be used and shared by authorized ACCES staff.

What information will be reviewed?

The following information:
Entire contents within your file for the purpose of monitoring, by NYSED ACCES, of Independent Living Inc.'s compliance with the eligibility requirements for ILCs and compliance with the CIL (Centers for Independent Living) Standards, including the following: Date of Birth; Gender; Race/Ethnicity (if provided); Employment and Education status; County where you reside; Veteran status and Disability information. Required documents, such as Consumer Rights and Responsibilities, Consumer Grievance, Individual Authorizations (Consents) and Documentation of Services will also be reviewed.

Please note: Information within your file will only be reviewed, and no contents of your file shall be removed, nor will any copies be made for this NYSED ACCES review.

You have a right to decline this authorization. Your services, the payment for your services, and your health care benefits will not be affected if you choose to decline. If you sign this form, you will have the right to revoke it at any time, except to the extent that the Independent Living program has already taken action based upon your authorization. To revoke this authorization, please write to the Chief Operating Officer of the Independent Living program in which you participate.

When will this authorization expire?

This authorization shall remain in effect for one year beyond the date it is signed unless it is revoked in writing.

USE AND DISCLOSURE COVERED BY THIS AUTHORIZATION
Please Check for Authorization or Declination:
☐ I hereby **AUTHORIZE** Resource Center for Accessible Living, Inc. and/or its Representatives
☐ I **DECLINE to give authorization** to Resource Center for Accessible Living, Inc. and/or its Representatives

To submit my file for **REVIEW ONLY** by the agency, individual, or employer identified below:
Name/Title or Organization: **NYSED ACCES**
Address: 89 Washington Avenue, Room 580 EBA, Albany, NY 12234
Phone: (518) 474-2925 | Toll Free: 1-800-222-5627 | Fax: (518) 473-6073

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Signature

I have read this form and all my questions about this form have been answered.

Signature of Consumer or Authorized Representative

Printed Name

Date

Description of Authorized Representative's Authority (Legal Guardian, etc.)

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Things to bring to Initial Budget Meeting

1. Bank Statement

2. Rental agreement or letter stating rental amount from landlord.

3. Bills
    a. Utilities (such as cable, electric, oil, or gas)
    b. Cell Phone
    c. Credit cards
    d. Medical Bills

4. Outstanding Loans (either the loan agreement or a letter signed by the lender; include amount due.)

5. Insurance bills (medical or auto)

6. Bereavement policies or already purchased burial plots.

7. Life insurance policies

8. Pay stubs