Community Crossroads

GUIDANCE. SUPPORT. ADVOCACY.

Community Crossroads Puts Clients First

A Partner Who Cares

At Community Crossroads, we are passionate about the smallest details of your unique and individual situation, and are committed to providing the best and most effective professional nonprofit representative payee services designed to not only enable families to successfully manage their money, but also live the quality of life they deserve.

We're Here When You Need Us

Convenience and availability is part of the Community Crossroads promise and commitment to quality service. We are open Monday – Friday from 8:30 AM to 4:30 PM

Safe and Secure Service

Our representative payee coordinators are trained to keep personal information safe and secure. We take pride in our ability to use the most secure technology designed specifically for safeguarding personal and proprietary information.

Thank you for considering Community Crossroads Representative Payee Services, we look forward to serving you.

Deanna Johnson
Representative-Payee Manager
603-893-1299 Ext. 323
djohnson@communitycrossroadsnh.org

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Representative Payee Service Application

-A 501(c)(3) Non-Profit-

Client Information:

Name:_____

Address:_____

City: _____State: _____ Zip: _____

Social Security: _____ Date of Birth: _____

Daytime Phone #: _____ Evening Phone# _____

Marital Status: ☐ Married ☐ Single ☐Divorced Employment: ☐Employed ☐Unemployed ☐Retired

Have you ever served in the Military? Y / N

Do you live alone?: _____ If not, name of person you live with /relationship _____

Landlord Name: _____ Landlord Phone Number: _____

Do you have a guardian? _____ If yes, guardian name & contact information _____

Current Payee Contact Information: _____

Mother's Maiden & Father's Names: _____

Client's Place of Birth (City & State): _____

Emergency Contact : (Name, Phone# & Relationship to you):

_____

Case Manager: (Name & Phone #): _____

I give Community Crossroads Payee Services permission to discuss my financial matters with my case worker, until written permission is given by me to cease the communication. _____

Referred by:

Organization: _____ Case Worker: _____

Phone #: _____

8 Commerce Drive, Unit 801, Atkinson, NH 03811 | Phone: (603) 893-1299 | Fax: (603) 893-5401

communitycrossroadsnh.org

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Hours of Operation: Monday through Friday 8:30 a.m. to 4:30 p.m.

Office: (603) 893-1299 Fax: (603) 893-5401

Andrea Lambert, ext. 329
alambert@communitycrossroadsnh.org
(e-mail is preferred)

- Account Questions
- Request for Funds
- Billing Questions

Jennifer Banks, ext. 363
jbanks@communitycrossroadsnh.org

- Payee Service Intake – Application Request
- Payee Service Questions
- Medicaid Questions / Redeterminations
- Document Request - Information Updates
- Employment Updates / Wage Reporting

SSI deposits on the 1st **SSA deposits on the 3rd** **SSDI deposits on the 3rd**

In the event that the 1st or 3rd falls on a Saturday or Sunday, the deposit will typically occurs the Friday before. Spending will be processed accordingly.

Community Crossroads Holiday Schedule

NEW YEAR'S DAY	TUESDAY, JANUARY 1, 2019
CIVIL RIGHT'S DAY	MONDAY, JANUARY 21, 2019
PRESIDENT'S DAY	MONDAY, FEBRUARY 18, 2019
MEMORIAL DAY	MONDAY, MAY 27, 2019
INDEPENDENCE DAY	THURSDAY, JULY 4, 2019
LABOR DAY	MONDAY, SEPTEMBER 2, 2019
COLUMBUS DAY	MONDAY, OCTOBER 14, 2019
VETERAN'S DAY	MONDAY, NOVEMBER 11, 2019
THANKSGIVING DAY	THURSDAY, NOVEMBER 28, 2019
DAY AFTER THANKSGIVING	FRIDAY, NOVEMBER 29, 2019
CHRISTMAS DAY	WEDNESDAY, DECEMBER 25, 2019

THE AGENCY WILL CLOSE AT NOON THE DAY BEFORE THE FOLLOWING HOLIDAYS:
• CHRISTMAS • NEW YEAR'S • JULY 4TH • THANKSGIVING •

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Account Information Authorization Form

Client Name: _____ Account #_____

I, _____, authorize Community Crossroads Representative Payee Department and its employees to speak on my behalf and obtain account information from: _____ .

This authorization will remain in effect for as long as I am a client with Community Crossroads Representative Payee Services or until revoked by me in writing.

_____ _____

Client / Guardian Signature: Date:

_____ _____

Authorized Representative Payee Date:

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Representative Payee Contract

I, _____herby appoint Community Crossroads to be my designated Representative Payee for my Social Security benefits, (SSI, SSDI) or other income including State cash assistance, VA benefits, and payroll. Community Crossroads shall receive my benefits and/or paychecks and be responsible to pay my financial obligations to the extent that there are available funds in my account to do so. Client agrees to pay a FEE of $25.00 per month. * Paid to Community Crossroads.

Community Crossroads will pay rent and utilities (or room & board) and all bills directly to the service provider. Community Crossroads will provide weekly/bi-weekly/monthly personal spending check or direct deposit to the client or designated individual as long as the client funds are available. Community Crossroads shall provide all designated Representative Payee services as prescribed by law or regulation.

The client agrees to the following:

1. Community Crossroads will make all payments by direct deposit or by check.
2. All monthly checks will be mailed by the 5th of each month. (Exceptions: Holidays & Emergencies)
3. The client must notify Community Crossroads in writing of any changes in address. If the client fails to do notify Community Crossroads in writing of any changes in address at least 10 days before the change or move, Community Crossroads shall not be held responsible by the client for any rent, room & board or other payments made by Community Crossroads on the client's behalf.
4. The client must notify Community Crossroads in writing of any changes in employment. This includes new employment and loss of employment. If the client fails to notify Community Crossroads in writing of any changes in employment within 5 days of the change, Community Crossroads shall not be held responsible by the client for any loss of benefits that this may cause.
5. Special funds request will be mailed or direct deposit within 5 business days.
6. Community Crossroads will make no advances on loans.

This agreement shall remain in force for a period of 12 months from the date of the execution and shall be automatically renewed unless cancelled by the Client with a written 30 day notice. Community Crossroads reserves the right to provide a Client cancellation notice to Social Security at any time.

Client:_____ Date:_____

Rep. Payee Manager:_____ Date:_____

*Client fees are regulated by Social Security and subject to change with 30 day notice.

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Voluntary Consent/Authorization & Request for Change of Payee Application

Client Name: _____ Social Security #: _____

Authorization

I, _____, hereby give Community Crossroads my authorization to file an application to be my payee. I understand this means that Community Crossroads will receive any SSI and/or SSA funds that I am eligible for. I understand that Community Crossroads will administer my benefits for me. I was referred to Community Crossroads by _____, who is my _____.

My Need For A Payee And My Selection For My Payee

The Social Security Administration has determined that I need assistance in managing my benefits. This means that by benefits will be sent to a representative payee who is responsible for managing my benefits in my best interest. I choose to have Community Crossroads as my representative payee.

My Rights

1. I understand that I have the right to appeal Social Security's decision as to who will be my representative payee. I will contact a social security office if I want to appeal.
2. I understand that I have the right to appeal the determination of social security that I need a payee. If I choose to appeal, I understand that I have the right to review the information in my file and that I can submit new evidence for consideration that if I do not file my appeal within 60 days.
3. I understand that if I do not file my appeal within 60 days that I must have a good reason for being late. I understand that I must ask for the appeal in writing and I will contact a social security office if I want to appeal.

Benefits Checklist

Beneficiary: _____

Federal Benefits:

- ☐ SSDI Monthly Amount : _____
- ☐ SSI Monthly Amount : _____
- ☐ VA Monthly Amount : _____
- ☐ Medicare Part: A B C D (circle)

State Benefits:

- ☐ Medicaid: APTD MEAD TANF
- ☐ Cash Assistance Monthly Amount : _____
- ☐ Food Stamps Monthly Amount : _____
- ☐ Cost Of Care Monthly Amount : _____
- ☐ Spend Down Monthly Amount : _____
- ☐ Mead Premium Monthly Amount : _____

Other Benefits & Assistance Programs

- ☐ Fuel Assistance Monthly Amount : _____
- ☐ Electric Assistance Monthly Amount : _____
- ☐ Housing Subsidy Monthly Amount : _____

Please include current award letters for Fuel and/or Electric Assistance

Do you have an ACTIVE housing voucher? Y/ N Section 8: Y /N Public Housing: Y /N (circle)

Client Monthly Bills Worksheet (1 of 2)

	Amount	Who is Paid /Address	Phone #, Account # & Description
Housing:			
Rent/Mortgage/Lot Rent			
Due Date: _____			
Electric:			
Due Date: _____			
Gas:			
Due Date: _____			
Cell:			
Due Date: _____			
Phone/Home:			
Due Date: _____			

Expenses from this Page:

Client Monthly Bills Worksheet (2 of 2)

	Amount	Who is Paid /Address	Phone #, Account # & Description
Cable:			
Due Date: _____			
Food:			
Due Date: _____			
Other:			
Due Date: _____			
Other:			
Due Date: _____			
Other:			
Due Date: _____			

Total Monthly Expenses:

If you receive Medicaid benefits and you are asking Community Crossroads to take over this responsibility of being your representative payee for Medicaid as well, please sign the next page and return to us with the packet. This will allow us to take care of your NH Medicaid.

NH Department of Health and Human Services (DHHS)
Division of Family Assistance (DFA)

DFA Form 778
12/14 rev 1/15

AUTHORIZED REPRESENTATIVE (AR) DECLARATION

You may choose an Authorized Representative (AR) to help you with some or all of the steps needed to apply for or get benefits. These benefits include: cash, medical, Food Stamps, and/or Child Care assistance.

An AR is a friend, family member, or other person who has a concern for your well-being. An AR is a person you choose. We will not choose one for you. The person you choose must agree to help you. An agency cannot act as an AR, but a person working at an agency can. An AR must be an individual person.

An AR may go to eligibility interviews for you. An AR may fill out an application form and other paperwork for you. An AR may also report changes in your income, resources, and other changes for you. The AR may get your Electronic Benefits Transfer (EBT) card, medical assistance ID card, and other mail from us. The AR may ask for an Administrative Appeal for you if you are not satisfied with any eligibility decision made by DHHS. The AR may also represent you at an Administrative Appeal. You get to choose what you would like the AR to do for you by checking the boxes below.

AUTHORIZED REPRESENTATIVE DUTIES

Please check off the things that you want the AR to do for you:

- [x] Get my application, forms and other DHHS paperwork for me.
- [x] Fill out my application, forms and other DHHS paperwork for me.
- [x] Give DHHS proof of my income, resources, and other case information, and report and verify changes in my case circumstances to DHHS for me.
- [x] Get my notices from DHHS.
- [ ] Get my EBT Card in their name.
- [ ] Get my EBT Card for me.
- [x] Ask for an Administrative Appeal for me.
- [x] Get my medical assistance ID card for me.
- [x] Get my cash benefits for me.
- [x] Go to my eligibility interviews for me.
- [x] Represent me at an Appeal if I decide I want one.
- [x] Other: Speak on my behalf

CLIENT'S SIGNATURE

Please read the following statements carefully. Your signature below means you have read, understand, and agree to these statements.

- **I certify** that I have read and understand the information on this form.
- **I understand** that I am responsible for any errors, omissions, or inaccurate information that my AR reports to the District Office.
- **I understand** that if my AR uses my benefits without my permission, these benefits will not be replaced or reissued by DHHS.
- **I understand** that the person I named as my AR will continue to act for me until I tell DHHS in writing of a change. However, if I am living at a drug and alcohol treatment center or am part of another group living arrangement and my AR is an individual employed by that agency, I understand that in accordance with 7 CFR 273.10(f)(5)(ii), that individual will automatically no longer be my AR once I leave the treatment center.

Client's **Printed** Name _____ Date _____

Client's Signature _____ Date of Birth _____

MID # _____ Case # _____

(Please Turn Over)

Client Consent to Grant NH EASY Access

Please see the information on page 2 of this form prior to completion.

Section 1 – To Be Filled Out By The Organization

Client Name: _____

Client Social Security #: _____ Case Number: _____

Organization Name: Community Crossroads

My organization does **not** want to complete this client's paper redeterminations online:

Organization Representative Signature: _____

Organization Representative Printed Name: Deanna Johnson / Area Agency

Documentation supporting your relationship with the client named above must be on file with DHHS before this form will be processed.

Section 2 – To Be Reviewed And Signed By The Client and/or Legal Representative

I understand that if I sign this form, **I agree to the following:**

- If I already have a NH EASY account, this account will be deactivated. I will no longer be able to access my old NH EASY account.
- I cannot have my own NH EASY account. I cannot go online to report changes, or apply for benefits. I cannot go online to see my case information, or read my letters and notices online.
- I can still report changes and apply for benefits by contacting my local District Office. I will receive my notices and letters in the mail.
- If I was getting my letters and notices online, I will now get paper letters and notices in the mail.
- Any authorized member of the organization above can report changes, add programs, reapply for benefits, update case information, and see all case information, notices and letters for *everyone in my household.*
- The organization above can choose to complete my paper redeterminations online. If the organization does not choose to complete my paper redeterminations online, I will be responsible for completing my paper redeterminations.
- I can stop the organization from having a NH EASY account for my case by contacting my local District Office. I can then have my own NH EASY account, if I want a NH EASY account.

Client Signature: _____ Date: _____

Legal Representative Signature: _____

Legal Representative Printed Name: _____ Relationship to Client: _____

Please return to the Central Scanning Unit, PO BOX 181, Concord, NH 03302

If you receive Social Security benefits and you are asking Community Crossroads to take over this responsibility and you currently do not have a Rep Payee, the next two pages need to be bought to your doctor for their signature. Once signed, please return to us with your packet.

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.

I 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

Below you will find a list of required documentation that must be returned, if applicable, to Jennifer Banks in the Rep Payee Department:

- Front & Back copy of your Non- Drivers I.D. or License
- Copy of your Social Security Card
- Copy of Medicare/Health Insurance Cards
- Copy of Car Registration
- _____

Also, please immediately notify Jennifer in the Rep Payee Department of the following changes:

- Employment
- Address
- Personal Contact Information

jbanks@communitycrossroadsnh.org