### PHYSICIAN'S/MEDICAL OFFICER'S STATEMENT OF PATIENT'S CAPABILITY TO MANAGE BENEFITS

Paperwork Reduction Act Statement - This information collection meets the S.C. § 3507, as amended by Section 2 of the Paperwork Reduction Act of 1993 answer these questions unless we display a valid Office of Managemen number. We estimate that it will take about 10 minutes to read the instructions answer the questions. SEND OR BRING THE COMPLETED FORM TO YOU SECURITY OFFICE. You can find your local Social Security office throu www.socialsecurity.gov. Offices are also listed under U.S. Government telephone directory or you may call Social Security at 1-800-772-1213 (Send only comments relating to our time estimate above to: SSA, Baltimore, MD 21235-6401.	95. You do not need to and Budget control s, gather the facts, and OUR LOCAL SOCIAL ugh SSA's website at nt agencies in your (TTY 1-800-325-0778).	In replying, use this address: SOCIAL SECURITY ADMINISTRATION
		TELEPHONE NUMBER (Including Area Code)
		( ) -
		DATE
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		SSA CONTACT
to provide all or part of the information could prevent an accurate and tir proper payee for benefit receipt purposes.	IDENTIFYING INFORMATION (SSA Only) If different from patient	
We rarely use the information you supply for any purpose other determination on a claim. However, we may use it for the administration a Security programs. We may also disclose information to another person in accordance with approved routine uses, which include but are not limit		
third party or an agency to assist Social Security in establishing right benefits and/or coverage; (2) to comply with Federal laws requiring the refrom Social Security records (e.g., to the Government Accountability Offic Veteran Affairs); (3) to make determinations for eligibility in similar maintenance programs at the Federal, state, and local level; and (4) tresearch, audit or investigative activities necessary to assure the integriprograms.	NAME OF WAGE EARNER OR SELF- EMPLOYED PERSON	
We may also use the information you provide in computer matching programs compare our records with records kept by other Federal, state agencies. Information from these matching programs can be used to person's eligibility for Federally funded and administered benefit program of payments or delinquent debts under these programs.	SOCIAL SECURITY NUMBER	
A complete list of routine uses for this information is available in System 60-0089 and 60-0222. The notices, additional information regarding this fregarding our programs and systems, are available on-line at <a href="https://www.socials.org/linearing-color: blue;">www.socials.org/linearing-color: blue;</a> of the systems are available on-line at <a href="https://www.socials.org/linearing-color: blue;">www.socials</a> local Social Security office.	ns of Record Notices form, and information	
PATIENT'S NAME PATIENT'S NAME	'ATIENT'S ADDRESS (Nu	umber and Street, City, State, and ZIP Code)
PATIENT'S SOCIAL SECURITY NUMBER PATIENT'S DATE OF BIRTH		
VOLID LIELD IO MEEDED		

# 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	PATIENT'S DATE OF BIRTH				
Date you last examined the patient	<u> </u>				
Do you believe the patient is capable of ma     By capable we mean that the patient:	anaging or directing the	management of b	enefits in his or he	er own best interest?	
<ul> <li>Is able to understand and act on the ord clothing, etc., and</li> </ul>	dinary affairs of life, suc	ch as providing for	own adequate foc	d, housing,	
Is able, in spite of physical impairments	, to manage funds or di	rect others how to	manage them.		
☐ Yes	☐ No			nsure	
If "Yes", please omit question 3, but be sure to sign and date the form.				If "unsure", please explain.	
Do you expect the patient to be able to manage	e funds in the future (fo	r example, the pati	ent is temporarily	unconscious)?	
■ Yes	□ No			·	
If yes, please explain.					
NAME OF PHYSICIAN/MEDICAL OFFICER (Ple	ase 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 e forms, and it is true and correct to the best of misleading statement about a material fact in sent to prison, or may face other penalties, or	my knowledge. I unde	erstand that anyo	ne who knowing	ly gives a false or	
SIGNATURE OF PHYSICIAN/ MEDICAL OFFICER				DATE	

Form **SSA-787** (05-2010) ef (05-2010)