Thanks for your interest in Michigan Ability Partners' Payee Program.

The enclosed application packet describes services, rules, and expectations of the client/representative payee relationship. A Payee department rep will contact potential clients or their designee within about one week of receipt of this completed application (usually by phone) to set up an appointment at MAP offices.

At that appointment, we will fully explain the program, a budget will be prepared, and other details of client's financial services plan will be determined.

Depending on what day in the month a client signs up, it can take up to 30 days to complete the transfer/setup of accounts with SSA or other source of income, before payee services begin.

Please read all material thoroughly, complete General Intake Application and other information as you are able, and return all pages to either Ann Arbor of Jackson Office based on your location.

Michigan Ability Partners 3810 Packard, Suite 260 Ann Arbor, MI 48108-2054	***OR***	Michigan Ability Partners 216 E. Biddle Street, Suite 200 Jackson, MI 49203

You can leave some portions blank until your appointment if you wish. A MAP representative will help you complete the rest of this application at your appointment, including the Release of Information form.

You may also return this application in person. Ann Arbor MAP is open Monday and Friday from 9:00 a.m. – 12:00 NOON and 1:00 p.m. – 4:30 p.m. (excluding national holidays). We are located on the AATA number 5 bus route, in the Packard Office Center on Packard between Carpenter and Platt Roads. Look for the "Gentle Dental Foot & Ankle" sign—our offices are next door with large address numbers on our buildings. 3810 is the second building from the road; Suite 260 is on the second floor. The Jackson MAP office is open Monday and Friday from 9:00 a.m. – 12:00 NOON and 1:00 p.m. – 4:30 p.m. (excluding national holidays).

We look forward to serving you.

Welcome to the Michigan Ability Partners Payee Program

Our Payee Program prides itself in making sure that your experience with us is an enjoyable one. We understand that managing your own money can be overwhelming, and losing the ability to manage it can be difficult. Michigan Ability Partners (MAP) Payee Program is here to alleviate that pressure from you. We have helped many people to rebuild and maintain their credit with the eventual goal of regaining their financial independence.

Mission Statement

MAP's Payee Program provides representative payee services and financial management assistance to people experiencing financial barriers. This mission is accomplished through incorporating money management skills education and individualized services based on client needs. Payee program goals include assisting clients with increasing money management skills, increasing financial stability, building and maintaining credit, and promoting self-sufficiency toward financial independence.

MAP Payee Program Service Goals and Objectives

Goal #1: Increase Money Management Skills

Objectives

1. Provide group financial education workshops.
2. Provide individualized financial counseling.

Goal #2: Increase Financial Stability

Objectives

1. Provide assistance to clients with monthly budget development.
2. Network and communicate with client support system (i.e., Social Security Administration, Veterans Administration, creditors, family, friends, service providers) to maintain support.
3. Provide support around financial responsibilities (i.e., distribution of personal needs money, direct bill payment services).

Goal #3: Build & Maintain Credit Status

Objectives

1. Advocate and negotiate with creditors.
2. Develop and maintain debt payment plans.

Goal #4: Promote Self-Sufficiency

Objectives

1. Share community resources with clients.
2. Provide client-centered services.

Who is eligible for services?

- Individuals experiencing financial barriers/difficulties
- Individuals interested in addressing financial barriers

Fees for Services

SSI/RSDI/SSD clients:	$52 per month
Group Home Clients receiving $900 or less per month:	$19 per month
Group Home Clients receiving more than $900 per month:	$52 per month
Miscellaneous income/wages:	$52 per month

Sliding Scale may be available on an individual basis.

Referral Process

To inquire about services or make a referral, anyone can contact the offices: Ann Arbor: Phone (734)975-6880 Fax: (734)975-2956. Jackson: Phone: (517) 841-5780 Fax: (517) 795-1400. Michigan Ability Partners, 3810 Packard, Suite 260, Ann Arbor, MI 48108-2054 or 216 E. Biddle Street, Suite 200, Jackson, MI 49203.

For MAP Office Use Only

Date Application Received

General Intake Application

I. Participant Data

Name (Last, First, Middle Initial)			Social Security Number		Date of Birth
Address			City	County	Zip Code
Phone Number (Include Area Code)			___ Voice ___ Fax ___TTY	Email Address	
Race/Ethnicity	Hispanic Origin ___ Yes ___ No	Multi-Racial ___ Yes ___ No	Are you a Veteran? ___ Yes ___ No		Sex ___ M ___F
Marital Status ___ Never Married ___ Married ___Divorced ___Widowed ___ Separated			Voter Registration ___ Currently Registered ___ Not Registered		
Who referred you to Michigan Ability Partners?					
Primary Disability		Cause	Limitations		
Other Disability		Cause	Limitations		
Are you currently under a physician's care for your disability? ____ Yes ____ No			Physician's Name		
Physician's Address (Street, City, State, Zip)					
Are you currently covered by Health Insurance? ____ Yes ____ No Name Coverage_____					
Do you have a Guardian? _____Yes _____No					
Case Worker's Name:					
Case Worker's Phone Number:					
Mother's Maiden Name:		Clients Birthplace:			
Do you have a Michigan Driver's License/ State ID? ____ Yes #_____ ____ No		Do you have a car, van or truck? ____ Yes ____ No What is your means of transportation? _____			
What services are you requesting from Michigan Ability Partners? ___Housing ____ Employment ____ Payee ___ Mental Health ___ Substance Abuse ___ Other (specify) _____					

II. Sources of Financial Assistance (which are you receiving)

Check those that apply and indicate amount

____ SSI $_____ Mo. ____ SSDI $_____ Mo. ____ TANF (FIP) $_____Mo.

____ State Disability Assistance $_____ Mo. ____ Food Stamps $_____ Mo.

____ Unemployment Compensation $_____ Mo. ____ Worker's Compensation $_____ Mo.

____ V.A. Benefits $_____ Mo. ____ Other _____ $_____

III. Education

High School Diploma ____ Yes ____No	School at Application	Have you earned a General Education ___No Development Certificate (GED)? ___Yes
Degree and Certificate Earned	Field of Study	
Other Training or Job Skills		

IV. Employment Data

Are you Currently Employed? ____ Yes ____ No	What types of jobs have you held in the past year?	How many jobs have you had in the past year? _____
1. Employer Name (Most Recent)	Address	City
Dates of Employment _____ To _____	Wages	Reason for Leaving
Job Duties		
2. Employer Name	Address	City
Dates of Employment _____ To _____	Wages	Reason for Leaving
Job Duties		
3. Employer Name	Address	City
Dates of Employment _____ To _____	Wages	Reason for Leaving
Job Duties		

V. Emergency Contacts

Name	Relationship	Telephone Number
Address		
Name	Relationship	Telephone Number
Address		

VI. Members of Your Household

1. Name	Relationship	Age	Name of Employer	Wage
2. Name	Relationship	Age	Name of Employer	Wage
3. Name	Relationship	Age	Name of Employer	Wage

VII. Participant Signature

Your signature below means you are applying for MAP services and giving consent for a criminal background check and release of information to contact Emergency Contact if necessary.

Participant's Signature (Parent or Guardian if applicable)	Date

VIII. Michigan Ability Partners Representative

The application has been reviewed, the participant has been provided an orientation to Agency Services, and their rights and responsibilities have been discussed.

Michigan Ability Partners Staff Signature	Date

MAP Payee Program Rules and Expectations

I, _____ , consent to participate and to adhere to the rules and expectations of the Representative Payee Program through Michigan Ability Partners.

Client Initials:

_____ 1. I understand that MAP will be appointed by the Social Security Administration to be my Representative Payee. MAP may also be authorized by me to administrate funds deposited by the Veterans Administration and/or from my own earnings/wages. If MAP becomes the Representative Payee, then MAP will manage all Social Security and Veteran's Administration benefits and/or earnings/wages through a bank account, and I will request checks from my MAP representative payee to take care of my needs.

_____ 2. I understand that as a Payee, MAP is required by law to use benefits and other funds properly. MAP policy and the Social Security Administration guidelines state that, "…the beneficiary's day-to-day needs for food and shelter must be met." Funds in excess of basic needs will be administered per MAP guidelines to cover personal needs, to address credit issues and to create savings for future needs.

_____ 3. At the start of service, the Payee and I will assess financial barriers and work together to create a budget that will direct the course of my financial services. At that time, a schedule for picking up personal needs checks will be determined. Budgets will be reviewed as required due to changes in income, expenses, or long-range plans.

_____ 4. My Representative Payee will be responsible for:
- Paying my rent, utilities, personal needs money, and any other bills that are in the budget.
- Talking to creditors on my behalf to set up reasonable payment plans.
- Making any adjustments needed to my budget based on changes in bills.
- Filling out all required paperwork for SSA/VA.
- Keeping me informed of any changes/problems.

_____ 5. I will be responsible for:
- Notifying and providing MAP Payee Staff with the following information:
  - Change of address,
  - If I stop or start working,
  - Change in marital status,
  - If I start receiving another government benefit, or if the amount of the benefit changes,
  - If I am imprisoned for a crime that carries a sentence of over one month, or
  - If I move to or from a hospital, nursing home, or other institution.
- Providing pay stubs on a monthly basis to my Payee if I am working.
- Making sure that my Payee has my bills that need to be paid. This means that I can either have all my bills mailed directly to the Payee at MAP (preferred), or I can drop bills off to MAP in person.

_____ 6. I understand that if I have both the interest and the potential to develop self-directed money management skills, the Payee will work with me to create a plan to do so. This will include a phased process where the Payee and I will work together to create a plan for my financial independence.

_____ 7. The Payee Program will offer classes and workshops in which I can choose to participate.

_____ 8. I understand that MAP may need to discuss my personal finances with debtors in order to set up payment plans. I authorize MAP to discuss my finances with debtors to accomplish this goal.

_____ 9. I understand that MAP will not issue checks to support illegal activities including but not exclusive to buying or using illegal drugs, driving without insurance or a license, and/or buying stolen goods.

_____ 10. I understand that in addition to personal needs money received through my monthly budget, I may request checks for incidental expenses. Receipts may be required for extra or expensive purchases. Check requests for incidental expenses must be submitted and approved by MAP's Payee Staff by 12 p.m. on any business day in order for the check to be made available the following business day after 2:00 p.m.

_____ 11. For emergency same-day checks, MAP's Payee Supervisor must give written approval. Emergencies are considered on a case-by-case basis to determine if a same-day check will be issued.

_____ 12. I understand that MAP Staff will not tolerate disrespect by way of verbal threats, inappropriate comments and/or inappropriate physical behavior towards Payee staff or front office staff. Once warned, I understand that my services may be discontinued for a repeat of bad behavior.

_____ 13. I understand that no checks are given to clients under the influence of alcohol and/ or illegal substances. In addition, no one is allowed in the building under the influence of alcohol and/ or illegal substances.

_____ 14. I agree to the following monthly fees for service:

SSI/RSDI/SSD clients:	$52 per month
Group Home Clients receiving $900 or less per month:	$19 per month
Group Home Clients receiving more than $900 per month:	$52 per month
Miscellaneous income/wages:	$52 per month

Sliding Scale may be available on an individual basis.

_____ 15. I understand that I may terminate this relationship by providing a one-month notice through verbal or written notification. Should I choose to terminate services, I understand that the Social Security Administration, the Veteran's Administration, and/or my employer may require alternate payee services in order for me to continue timely receipt of my benefits.

I understand that the benefit I receive from these or other MAP services depends on my cooperation and active participation.

_____ _____

Participant Signature Date

_____ _____

Staff Signature Date

MAP Payee Program Participant Termination Policy

The MAP Payee Program may terminate enrollment of a participant who violates program requirements. Termination from the Payee Program is a final action taken when a situation is serious enough to warrant it or when a probationary contract has been refused or violated. MAP wants as many participants to be successful as possible. When there are unusual or special circumstances, MAP will take those factors into consideration.
MAP Payee Program Participants may be terminated for the following reasons:

- If the participant is found to be engaging in illegal activities, he/she may be terminated from MAP. A formal investigation will take place if there is suspicion of illegal activities. Refusal to cooperate fully with such an investigation will result in termination form MAP. If suspicions are confirmed by a formal investigation, the participant may also be terminated from payee services.
- Failure to agree to or follow terms of probationary contract will lead to termination from the payee services.
- Altering checks provided through the payee program will lead to termination from the payee services
- Physical or verbal aggression or threats of aggression may be grounds for termination from payee services.
- Failure to report wages, and changes in the following: address, marital status, other recurring income sources may lead to termination form payee services.

The following steps will take place once the MAP Payee Program staff determines that a participant has violated the program requirements and will be terminated:

1. Written notice will be sent to the participant containing a clear statement of the reasons for termination and acknowledging the previous verbal (or written) notice.
2. If the participant wishes, a review of the decision can be arranged, in which the participant is given an opportunity to present written or verbal objections to the termination hearing. See consumer grievance procedure for specific steps.
3. In the event a reversal of termination decision occurs following a review/grievance procedure, the participant will be expected to renew and resign his/her consent to participate and may, at the discretion of the payee team/team leader, be on a probationary status for a specified period of time before returning to full payee program status.
4. If termination occurs then conserved funds will be sent back to the Social Security Administration and the Social Security Administration will determine continued need for a payee.

I have read the above, have received an explanation, and I understand all of the conditions under which termination from the MAP Payee Program may occur.

_____ _____

Participant Signature Date

_____ _____

Staff Signature Date

Release of Information

I, _____, at _____
Participant Name Participant Address

Authorize Michigan Ability Partners to release and/or exchange information regarding myself, including my skills and abilities and the service I receive to:

____ Potential Employers ____ Current Employer ____ Parent

____ Referral Source ____ Guardian ____ Home Care Provider

____Other Service Agencies ____ Service Funding Source ____Social Security

____ Other (Specify) _____

The purpose of this disclosure is to:

____ Develop employment opportunities

____ Provide ongoing support

____ Obtain resources to sustain employment, housing and/or community opportunities/resources

____ Other (Specify) _____

The specific types of information I have agreed to be exchanged include:

____ Employment History ____ Educational Information

____ Diagnosis ____ Financial Information

____ Medication Information ____ Treatment Summary

____ Other (Specify) _____

This consent maybe revoked at any time by either a verbal or a written notice to Michigan Ability Partners.

This Consent will expire on _____
Date

_____ _____
Participant Signature Date Parent/Guardian Date

_____ _____
Witness Date Witness Date

MAP Payee Program Budget Worksheet

Monthly Income

SSI _____
SSD _____
VA _____
Wage _____
Misc _____

INCOME TOTAL

_____

Monthly Bills

Rent *	_____	Doctor	_____
Electricity	_____	Dentist	_____
Gas	_____	Medication	_____
Water	_____	Car Ins	_____
Telephone	_____	Bus Fare	_____
Cable	_____	Hair Cuts	_____
Cell Phone	_____	Laundry	_____
Payee Fee	_____	Misc.	_____
Food	_____	Distributed:	_____

(In the form of Check Kroger card Meijer card)

Personal Needs _____ Distributed: _____

DEBT TOTAL

_____

Landlord name/address: _____

_____

Debts _____

_____

_____

_____

_____

_____

DISTRIBUTION OF FUNDS:

PERSONAL NEEDS CHECKS / FOOD CARDS TO BE:

- ❑ *MAILED TO CLIENT*
- ❑ *PICKED UP AT MAP*
- ❑ *MAILED TO CSM*

SAVINGS TOTAL

_____

Notes: _____

_____

_____

_____

_____

Client Signature: _____ Date: _____

MAP Staff Signature _____ Date: _____

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 Michigan Ability Partners 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 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 SSA 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)

MICHIGAN ABILITY PARTNERS
VERIFICATION OF PAYMENT
GROUP HOME/AFC/HOTEL/MISC.

Date of move:

Client Name:

Landlord Name:

Client New Address and telephone number:

_____
_____

Mailing Address for Check/OR Pick-up by:

Monthly rental amount:

FOR SSI ONLY:

Are you related to the Landlord?

Does the Landlord live in the household?

Are there other members of the household? If so, please list their names and DOB:

Are the utilities expenses shared? What utilities will the tenant be responsible for?

Landlord Signature: _____

Printed name of Landlord: _____

Contact # for Landlord: _____

Client Signature: _____

This form can be faxed back to:

Fax #:_____

This form MUST be filled out before payment is made