PHYSICIAN’S STATEMENT FOR SOCIAL SECURITY PURPOSES

1. **Purpose:** The purpose of this procedure is to assure that the Social Security Payee Form is filled out in the best interest of the residents of Florida State Hospital with the most accurate and timely information available.

2. **References:**
   
a. Sections 205(a) and 205(j) of the Social Security Act, as amended 42 U.S.C. 405(a) and 405(j).
   
b. Florida State Hospital Operating Procedure 151-19, Confidentiality/Release of Information.

3. **Training Requirements:** Physicians and Advanced Registered Nurse Practitioners will be trained on this operating procedure upon hire into the position during Discipline-Specific Education and by their supervisor each time the operating procedure is revised. Health Information Services staff will be trained upon hire into the position during Worksite Education.

4. **Procedure:**
   
a. The Florida State Hospital Social Security Coordinator, located in Central Health Information Services, will forward Form SSA-787 (see Attachment) to the Health Information Specialist in the resident’s home unit.
   
b. The form will then be forwarded to the resident’s attending physician for completion.
   
c. The completed form should be routed back to the unit’s Health Information Specialist/designee, who makes a copy for inclusion in the Correspondence section of the resident’s medical record. The original is then returned to the Social Security Coordinator within seven (7) days of initiation.
   
d. If medical information is requested on the SSA-787 form, the unit’s Health Information Specialist/designee shall prepare the copies after ensuring appropriate release of information has been obtained. The medical information, along with the original SSA-787 shall be forwarded to the Social Security Coordinator within seven (7) days of initiation. All copies of records should either be pre-printed or stamped with “confidential and privileged information.” A copy of the SSA-787 form will be filed in the master record.
e. Florida State Hospital Social Security Coordinator will:

(1) review the SSA-787 form and packet for completeness and appropriate signatures and forward to the Social Security Office within two (2) days of receipt of the information, and

(2) input the required information into the Disclosure Log within one (1) week of disclosure.

(Signed original on file in Central Health Information Services)

DIANE R. JAMES                      Attachment
Hospital Administrator             Form SSA-787

SUMMARY OF REVISED, ADDED, OR DELETED MATERIAL
This procedure was revised to include the spelling out of acronyms/abbreviations.
PHYSICIAN'S/MEDICAL OFFICER'S STATEMENT OF PATIENT'S CAPABILITY TO MANAGE BENEFITS

In replying, use this address:
SOCIAL SECURITY ADMINISTRATION

TELEPHONE NUMBER (Include 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. 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 that 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 Sign 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.

NAME OF PHYSICIAN/MEDICAL OFFICER (Please print.)

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 or misleading statement about a material fact in this information, or causes someone else to do so, commits a crime and may be sent to prison, or may face other penalties, or both.

SIGNATURE OF PHYSICIAN/MEDICAL OFFICER

DATE

Form SSA-787 (11-2002) EF (11-2002)
Attachment
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