DIVISION OF MENTAL HEALTH AND HOSPITALS

Administrative Bulletin Transmittal Memorandum No. 42

June 2, 1983

SUBJECT: Administrative Bulletin 7:14
Guidelines for Determining Whether or not a
Patient Receiving Social Security Benefits
Requires a Representative Payee

This Administrative Bulletin provides guidelines for determining a patient's capability to manage his/her Social Security benefits and prescribes procedures for securing the designation of a representative payee.

Richard H. Wilson, Director
Division of Mental Health and Hospitals

RHW:PK:er

DIVISION OF MENTAL HEALTH AND HOSPITALS

ADMINISTRATIVE BULLETIN 7:14

DATE: June 2, 1983

SUBJECT: Guidelines for Determining Whether or not a Patient Receiving Social Security Benefits Requires a Representative Payee
Applicability: H

I. Introduction

A. Capability Determinations

1. Some patients who are eligible for Social Security benefits are not capable of managing their benefits properly or protecting their own interests because:

   a. they use poor judgment in the use of their benefits, because of their mental condition;

   b. they are vulnerable to exploitation or the theft of benefits or property;

   c. they may exploit other patients in their use of benefits;

   d. they fail to fulfill their legal responsibility for maintenance;

   e. they fail to conserve their funds for their needs upon discharge; or

   f. they accumulate more than $1500 and thus become ineligible for Supplemental Security Income (SSI) and Medicaid;

2. The Social Security Administration has the authority to designate a person, such as a relative or the Chief Executive Officer of a hospital, to be the representative payee for a patient whom a physician has determined to be incapable of managing his/her own benefits. Such a person will receive the patient's Social Security checks directly and will be expected to use the funds received for the benefit of the patient and in fulfillment of the patient's obligations.

3. Hospital physicians who make the "capability" determinations that the Social Security Administration relies upon in deciding whether a patient may receive his/her benefits directly, do not have clear guidelines for making these determinations. In the absence of guidelines, decisions are made which are not uniform and, therefore, not equitable.

B. Collection Practices

1. A patient who receives his/her own benefits is permitted to accumulate up to $500, from Social Security payments or other income sources, in his/her individual patient account at the hospital. Accumulations beyond this amount are taken by the State for maintenance payments, except for $25/month which is given to each such patient as a personal needs allowance (PNA). In addition, a patient is permitted to accumulate up to a maximum of $1500 in financial resources which will consist of the initial $500 exemption, unspent PNA, interest, non-recurring wages and donations from outside the facility (see Attachment A: OMBC 4:02-13).

2. The county of a patient's legal settlement and the State may place a lien on the patient's outside bank account.

3. The county of a patient's legal settlement and the State will attempt to collect money from a person who is a representative payee for a hospital patient. They will also notify the Social Security Administration if a representative payee does not contribute to the cost of a patient's hospitalization.

4. When the Chief Executive Officer of a hospital is appointed representative payee for a patient, the patient's checks are deposited in his/her own hospital account. In these cases, the patient's money is treated as in OMBC 4:02-13.

C. Objectives

The objectives of the procedures described below are:

1. To permit patients to use and save their Social Security benefits responsibly for their current and future needs.

2. To protect the Social Security benefits of patients who are not capable of protecting their own money.

3. To assist patients in avoiding ineligibility for SSI and Medicaid.

4. To establish procedures that more consistently and equitably permit the State to collect money from patients for the costs of their hospitalization.

II. Procedures

A. Frequency of Treatment Team Reviews

The treatment team of each patient who is receiving Social Security benefits shall meet with the patient to address the question of the patient's capability to handle benefits:

1. Within 3 to 4 weeks of patient's admission to the hospital.
2. Six months after admission.
3. Every three months thereafter.
4. As soon as discharge planning begins.

B. Completion of Forms

Forms shall be completed or updated by the team social worker before the treatment team review. These forms shall include the following information:

1. Name, unit, hospital, age, type of benefit, monthly amount.
2. Date of admission, estimated discharge date.
3. Date of physician exam, date of team meeting.
4. Prior hospitalizations, current diagnosis, level of functioning, placement in the hospital.
5. Name of patient's legal guardian or representative payee, if any. State whether the guardian or representative payee gives money to the patient and uses the money for the patient's benefit.
6. State whether the patient is a drug or alcohol abuser.
7. Discharge plans, income, resources, residence, day programs, training or employment.
8. Pre-hospitalization income, resources, residence, day programs, training or employment.
9. Current financial needs and resources; eligibility for and/or receipt of public benefits.
10. Assessment of the patient's ability to manage his/her money, including the patient's actual use of money, demonstrated capacity to use or save his/her own money for his/her current and future financial needs, vulnerability to exploitation, demonstrated capacity to develop and follow a budget and record of payment for hospital maintenance.

Note: The team social worker should meet with the patient to discuss these issues prior to the treatment team meeting. If it appears that the patient is unable to, or does not want to, handle his/her benefits, the treatment team shall notify the Supervisor of Patients Accounts that the patient needs (wants) a representative payee.

C. Purposes of Treatment Team Reviews

The purposes of these team reviews are:

1. To develop or review the patient's capability to manage Social Security benefits.

2. To assist the patient in using his/her money in his/her best interests.

3. To assist the patient in saving money for his/her needs upon discharge.

4. To assist the patient in preserving his/her SSI and Medicaid eligibility.

5. To formally notify, on a timely, adequately documented basis, the Supervisor of Patients Accounts and the Social Security Administration of changes in the patient's capability status.

6. To formally notify, on a timely, adequately documented basis, the Supervisor of Patients Accounts and the Social Security Administration if a legal guardian or representative payee is using the patient's Social Security benefits inappropriately.

D. Standards for Determining Capability

1. If the patient is legally incompetent, he/she is not capable (of managing benefits).

2. If the patient is eligible for SSI benefits solely because of a disability and he/she has been medically determined to be a drug addict or alcoholic, he/she is not capable.

3. If the patient is under 18 years of age, he/she is not capable unless he/she has clearly demonstrated the ability to manage benefits. Consider, in particular, the information in B1-2, B7-10 above and the following:

a. If the minor is a parent, applying for him/herself and his/her child, who has demonstrated experience in handling his/her own benefits, it may be appropriate to find the patient capable.

4. In all other cases, consider whether the patient has demonstrated the ability to manage money. Consider in particular the problems identified in Section I.A.1. (a-f) and the following:

a. the amount of money available to the patient;

b. the actual use of money by the patient;

c. estimated length of stay;

d. current financial needs and resources, including Social Security benefits and other income;

e. projected financial needs and resources upon discharge;

f. the patient's demonstrated capacity to plan and budget for his/her current and future needs and follow through on such plans and budgets.

Example: A patient who has not been able to conserve his/her funds in anticipation of a foreseeable discharge or who loses money or permits others to exploit him/her, even with assistance from hospital staff, might benefit from having a representative payee. Conversely, a patient who has substantial resources and has accumulated a large sum of money outside of the hospital, but has not made any payments for hospital costs even after counseling by hospital staff, should be considered incapable of fulfilling his/her financial responsibilities and found not capable.

E. Social Security Reports

The following information should be included in reports to the Social Security Administration:

1. Name, age, Social Security account number, type of benefit.

2. Date of treatment team meeting; date of physician's examination.

3. Reason(s) for determining patient to be incapable of managing benefits:

a. patient's legal incompetency;

b. patient's drug or alcohol abuse, if any;

c. under age 18;

d. other.

4. If the hospital recommends that a representative payee be designated, the report should include the name and address of any relatives that have indicated their willingness to act in this capacity.

5. Information supporting the basis for the recommendation.

F. Report of Determination of Capability/Incapability

In all cases the treatment team will send a report of the patient's capability or incapability to manage benefits to the Supervisor of Patients Accounts. If appropriate, the Supervisor of Patients Accounts will make application to the Social Security Administration for the institution to become payee, but at the same time, will submit available information relative to family members available to serve as representative payee.

Richard H. Wilson, Director
Division of Mental Health and Hospitals

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Attachment A
A.B. 7:14

DEPARTMENT OF HUMAN SERVICES

INTER - OFFICE COMMUNICATION

To: See Distribution **Date:** 12/6/79

From: Herbert J. Horowitz
Assistant Commissioner

Subject: OMBC 4:02-13 - Management of Institutionalized Patients'/ Residents' Funds

The attached OMBC is being disseminated for implementation at the institutional level. The same information is being released as Administrative Order 2:05. The policies have been developed with input from the Title XIX Mental Health Task Force which includes representatives from DMH, DMR, DPW, the Deputy Commissioner's Office, the Comptroller's Office, and my office. They are designed to alleviate the considerable confusion which has surrounded this complex changing topic and to establish uniformity of procedure and operations in the institutional maintenance collection process and in the management of patients'/residents' funds.

Mr. Sant'Angelo's office will have the primary responsibility for oversight of the implementation and functioning of these procedures. However, it is essential to the success of these new policies that divisional fiscal officers and institutional business office staff carefully implement and monitor these procedures.

Thank you for your patience and cooperation in their development. Please direct all inquiries to George Dearborn, Bureau of Collections and Adjustments.

HJH:kam
Att.
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Mr. Steve Faluvegi
Mr. Larry Donahue
Ms. Joann Gibson

OMBC 4:02-13*

DEPARTMENT OF HUMAN SERVICES
OFFICE OF MANAGEMENT AND BUDGET

Office of the Comptroller

EFFECTIVE: December 1, 1979 LAST REVISED: November 15, 1979

SUBJECT: Management of Institutionalized Patients'/Residents' Funds

This OMBC establishes the policy and procedures for the management of institutionalized patients'/residents' funds and the maintenance collection process.

I. GENERAL POLICY

A. All patients/residents, Medicaid or non-Medicaid eligible, will be treated equally with regard to the administration of their income.

II. PROCEDURES

A. All patients/residents are entitled to a monthly Personal Needs Allowance (PNA) currently set at $25. This PNA may be in the form of a Supplemental Security Income (SSI) check or as the protected portion of a higher amount of the individual's total monthly income.

B. The Department is requesting State appropriated funds in FY 1981 for the purpose of providing the monthly PNA to non-Medicaid patients/residents with no income or less than $25 per month income. If funds are appropriated, the Department intends to implement this policy for non-Medicaid eligible patients/residents effective July 1, 1980. More detailed instructions will be forthcoming at that time.

The PNA is intended to meet the personal needs of institutionalized individuals and must be spent as the patient wishes. The following list provides examples of acceptable expenditures of PNA and

*Also Administrative Order 2:05

should be used by the facility staff in counseling patients/residents in the proper utilization of these funds:

Small purchases: deodorant, cosmetics, electric shavers, hair spray, lotions, powders, special soaps, shampoo, hair or clothes brushes, tobacco, candies, and ice cream.

Personal items: Articles of clothing, jewelry, watches, accessories, haircuts, beauty parlor, newspapers, and magazines.

Contacts with the Community: Home visiting, luggage for a home visit, trips to special events or places of interest, long distance telephone calls, personal stationery, postage stamps, gifts for the family.

Personalization of Living Area: A patient/resident may wish to make his living area more "home-like" with a colorful bedspread, rug, pictures, personally-owned chair, chest, etc., of a type not furnished by the facility.

Recreation and Hobbies: Games, photographic materials, aquariums, plants, radios, recorders, television sets.

C. All patients/residents with less than $500 of resources will be permitted to retain up to $500 of their monthly recurring income before any maintenance collection is taken. For example, if a patient/resident has $200 at time of admission or as of the effective date of this policy, he will be permitted to retain the next $300 of the monthly recurring income for a total of $500.* The $500 exemption is to be allowed only once. Future accumulation will only be permitted from unspent PNA, interest, wages and donations from outside the facility.

D. All patients/residents will be permitted to accumulate income from existing resources, PNA, interest, wages, and donations up to a maximum of

*It should be noted, however, that for Medicaid eligible patients/residents, the Medicaid billing will net out the Medicaid billing will net out the individual's available income even though no maintenance collection is being taken until the $500 limit is accumulated.

$1,500, which is the total financial resource ceiling for maintenance of Medicaid eligibility. The $1,500 limit will also be applied to non-Medicaid eligibles. When total resources exceed this level, Medicaid eligibility is lost. Monitoring of patients'/residents' accounts by the institutional staff is essential to avoid exceeding the $1,500 ceiling and losing Medicaid eligibility.

The patient/resident, guardian or custodian, however, may choose to reduce excess funds by applying some of the accumulated income toward the cost of his/her care. By applying no less than twelve (12) months worth of accumulated PNA income (12 x 25 = $300), the patient/resident will be assured that PNA funds will not cause an eligibility problem for at least a year. In this event, the facility is required to submit checks payable to the "Treasurer, State of New Jersey," and direct them to the Chief, Bureau of Collections and Adjustments, Department of Human Services, P.O. Box 1237, Trenton, New Jersey 08625. The Bureau of Collections and Adjustments will regularly report to the Division of Medical Assistance and Health Services' Bureau of Claims and Accounts all recoveries from Medicaid eligible patients/residents.

E. All income as shown on the PA-3L in excess of PNA (currently $25), interest, wages, and deductions for maintenance of spouse, home and dependents in the community, must be collected.* Collection is to begin after the initial $500 of resources and/or income has been exempted from maintenance collection. This procedure will only be followed for institutionalized individuals for whom the Department is the representative payee or where the client's representative payee in the community agrees to contribute the patient's/resident's funds in accordance with the PA-3L.

F. Wages which appear on the PA-3L as available income should be deducted from the Medicaid billing and will be netted out of the Medicaid payment; however, they should not be collected. Patients/residents must be allowed to retain wages earned from sheltered workshops, institutional jobs, or other work experiences.

*This includes SS checks, VA benefits, Railroad Retirement benefits, pension funds, etc.

G. The Department is in the process of implementing a revised and automated patient/resident funds accounting system. Every patient/resident will have an individual savings account established for him/her and interest will be credited to each individual's account, regardless of Medicaid status. The system will "flag" all individuals who are approaching the $1,500 limit to enable the facility staff to counsel them in the use of their funds, so they do not "save" themselves into ineligibility.

As monthly recurring income arrives at the institution, it is to be deposited in the patient's/resident's account. Maintenance amounts (all available income less PNA, interest, wages, outside donations, and allowable deductions) will be withdrawn prior to the end of the month and remitted to the State Treasury and/or the counties as in the past.

III. RESPONSIBILITIES

A. The Business Office of each institution is responsible for administration and monitoring of patient/resident funds, with general oversight provided by the Comptroller's Office. Divisional chief fiscal officers will be responsible for assuring that these procedures are carried out in a timely, efficient manner. Anything short of strict compliance results in inequitable treatment of clients and jeopardizes the State's participation in the Title XIX program, which supplies much needed resources to improve the quality of life of our institutionalized clientele.

B. This policy supersedes all previous instructions on this issue.

C. Please direct all inquiries to the Bureau of Collections and Adjustments.

A. P. Sant'Angelo

Anthony P. Sant'Angelo
Comptroller

Herbert J. Horowitz

Herbert J. Horowitz
Assistant Commissioner

Adm. Bulletin Book

DIVISION OF MENTAL HEALTH AND HOSPITALS

ADMINISTRATIVE BULLETIN 7:14

Date Issued: June 2, 1983 **Date Revised:** AUGUST 1, 1989

SUBJECT: Guidelines for Determining Whether or Not a Patient Receiving Social Security Benefits Requires a Representative Payee.

Applicability: This Bulletin applies to patients with an anticipated length of stay beyond four months.

I. Introduction

A. Objectives

The objectives of the procedures described below are:

1. To enhance patient responsibility and judgment in using their Social Security benefits for current and future needs.

2. To protect the Social Security benefits of patients who are not capable of handling their own funds.

3. To assist patients in maintaining eligibility for SSI and Medicaid.

B. Capability Determinations

1. Hospital physicians make the "capability" determination that the Social Security Administration relies upon in deciding whether a patient may receive his/her benefits directly. These physicians do not have clear guidelines for making these determinations. In the absence of guidelines, decisions are made which are not uniform and, therefore, not equitable.

2. Some patients who are eligible for Social Security benefits are not capable of managing their benefits properly or protecting their own interests because:

   a. they use poor judgment in the use of their benefits, because of their mental condition;

   b. they are vulnerable to exploitation or the theft of benefits or property;

3. The Social Security Administration has the authority to designate a person, such as a relative or the Chief Executive Officer of a hospital, to be the representative payee for a patient whom a Treatment Team has determined to be incapable of managing his/her own benefits. Such a person will receive the patient's Social Security checks directly and will be expected to use the funds received for the benefit of the patient.

C. Collection Practices

1. In the absence of a voluntary agreement authorizing the State to take a certain amount for maintenance, a patient who is self payee or who has an outside payee for his/her benefits is permitted to accumulate any amount in his/her patient trust fund.

2. Patients with the hospital as payee are normally pe[illegible] accumulate funds to a maximum amount equal to the current Medi[illegible]ource cap. Such patients may, however, accumulate funds in excess of that cap for discharge planning or special needs identified by the treatment team. In addition, PFC 84-2, "Management of Client Burial Funds," explains special rules exempting certain amounts from counting toward the resource cap.

3. To protect their eligibility, patients on Medicaid should be strongly encouraged to accumulate funds only up to a maximum amount equal to the current resource cap.

4. The county of a patient's legal settlement and the State will attempt to solicit voluntary contributions toward the cost of care and maintenance at the hospital from a person who is a representative [illegible] a hospital patient. They will also notify the Social Security [illegible]ation if a representative payee does not use a patient's funds for the benefit of that patient.

5. When the Chief Executive Officer of a hospital is appointed representative payee for a patient, the patient's checks are deposited in the patient's own hospital account. In these cases, the patient's money is treated as mandated in PFC 86-7.

II. Procedures

A. Frequency of Treatment Team Reviews

The treatment team of each patient who is receiving So[illegible]curity benefits shall meet with the patient to address the question o[illegible]atient's capability to handle benefits:

1. Within 40 days of patient's admission to the hospital.

2. If the initial review shows that the patient is incapable of handling money, the hospital physician shall complete and sign form SSA 7[illegible] described in Section II.B of this Bulletin. The Social Security Admi[illegible]n uses this form as a basis for determining the need for a rep[illegible] payee. If the Treatment Team determines that a patient is inc[illegible]handling money, it is recommended that a further review of this de[illegible]e scheduled within 60 days of the initial review, each 60 days thereafter and each 90 days beyond the first year of hospitalization. This schedule coincides basically with that of the regular treatment plan review. Between reviews, Treatment Teams should work with the incapable patient to develop and demonstrate the ability to budget and handle money. The physician should complete form SSA 787 for any change in capability status.

3. Patients who are capable and have increased access to their funds should be scheduled for review on an as-needed basis to be determined by the Treatment Team.

4. Regardless of capability, all patients are entitled to a review, if requested, within 30 days of the last review. Said reviews should be scheduled within seven days of request. Any further reviews necessary will be scheduled in conjunction with the regular treatment plan review.

5. Capability determination shall not be required for short-term patients whose length of hospitalization is expected to be four months or less.

B. Completion of Forms

SSA 787 forms shall be completed and signed by a hospital physician. Completed forms should go to the Supervisor of Patients' Accounts. These forms shall include the following information:

1. Name, address, hospital, date of birth, social security number, type of benefit.

2. Diagnosis.

3. Date of physician exam, or team meeting.

4. Prognosis.

5. Name of patient's legal guardian or representative payee, relative or other interested party.

6. Include in Treatment Team notes an assessment of the patient's ability to manage his/her money, including the patient's actual use of money, demonstrated capacity to use or save his/her own money for his/her current and future financial needs, vulnerability to exploitation, demonstrated capacity to develop and follow a budget.

NOTE: The team social worker should meet with the patient to discuss these issues. If it appears that the patient is unable to, or does not want to, handle his/her benefits, the treatment team shall notify the Supervisor of Patients' Accounts that the patient needs (wants) a representative payee.

C. Purposes of Treatment Team Reviews

The purposes of the treatment team reviews are:

1. To develop or review the patient's capability to manage Social Security benefits.

2. To assist the patient in using his/her money in his/her best interests.

3. To assist the patient in saving money for his/her needs upon discharge.

4. To assist the patient in preserving his/her SSI and Medicaid eligibility.

5. To formally notify, on a timely, adequately documented basis, the Supervisor of Patients' Accounts, who will then contact the Social Security Administration to request a change in the patient's capability status.

6. To formally notify, on a timely, adequately documented basis, the Supervisor of Patients' Accounts if a legal guardian or representative payee is using the patient's Social Security benefits inappropriately.

D. Standards for Determining Capability

1. If the patient is legally incompetent, he/she is not capable (of managing benefits).

2. If the patient is under 18 years of age, he/she is not capable unless he/she has previously demonstrated the ability to manage benefits. Consider, in particular, the information in Section I.B.2 and the following:

   a. If the minor is a parent, applying for him/herself and his/her child, who has demonstrated experience in handling his/her own benefits, it may be appropriate to find the patient capable.

3. In all other cases, consider whether there is documentation that the patient cannot appropriately manage his or her money. Consider in particular the problems identified in Section I.B.2 (a-b) and the following:

   a. the amount of money available to the patient;

   b. the actual use of money by the patient;

   c. estimated length of stay;

   d. current financial needs and resources, including Social Security benefits and other income;

   e. projected financial needs and resources upon disch[illegible]

   f. the patient's demonstrated capacity to plan and budget for his/her current and future needs and follow through on such plans and budgets.

      Example: A patient who has not been able to conserve his/her funds in anticipation of a foreseeable discharge or who loses money or permits others to exploit him/her, even with assistance from hospital staff, might benefit from having a representative payee.

E. Report of Determination of Capability/Incapability

The treatment team will send a report of any changes in the patient's ability to

) the Supervisor of Patients' Accounts. If indicated, the
ents' Accounts will make application to the Social Security
r the institution to become payee. Before applying, the
e a reasonable effort to find a relative or other interested party
sentative payee. At the time of application, the Supervisor of
ts shall notify the Treatment Team and the team will advise the
spital's intention to apply for payeeship.

ulletin is to assist in the protection of patient benefits. Patients
much of their own funds as is prudent and reasonable and as
Where necessary, hospital staff shall counsel patients in the
their funds. Treatment teams should always use consultations
ss in a positive manner.

Alan G. Kaufman, Director
Division of Mental Health and Hospitals