THE EPILEPSY CENTER OF NORTHWEST OHIO

Epilepsy Center of NWO
Payee Application

Date Received: _____
Waiver: _____
Sent to SS: _____

Thank you for your interest in the payee program offered by the Epilepsy Center of Northwest Ohio. In the following pages, you will find the necessary information to be completed and returned in order for ECNWO to review the application and begin the payee application process with the Social Security Administration.
Once ECNWO reviews the application and confirms our ability to serve the person requesting services, the timeline for this to begin will depend on the receipt of all necessary paperwork from the client/Service and Support Administrator and the processing of paperwork with SSA. ECNWO will update you with any information as we learn it during the application process.
Completed applications can be forwarded to Laurie Beaverson at lbeaverson@epilepsycenter.org or returned by mail to 1701 Holland Rd Maumee, OH 43537. Please email or call 419.867.5950 for additional information or with questions.

The following information will be needed to complete request for payee services:

□ Completed Payee Application
□ Payee Agreement Letter
□ Physician's/Medical Officer's Statement (if first time applying for payee)
□ Current ISP
□ CPT with ECNWO as provider, 20 hours for set-up of payee, 6 hours a month for payee services.
□ Release of information for ECNWO and any people that ECNWO will be authorized to speak with
□ Copy of State ID or Driver's License
□ Copy of Social Security Card

Once confirmation has been received from Social Security that ECNWO has been named as the payee, a meeting will be held to establish the budget for the individual. At that time, we will need to be sure that all of the following is available (as applicable):

□ Rent (with copy of lease)
□ Utility Bills including Gas, Electric, Water, Phone
□ Cable, Internet, Cellular
□ Renter's Insurance
□ Other Insurance- Burial Plans, etc.
□ Patient Liability
□ Other Expenses (that should be included as a monthly payment or part of monthly budget)

During the meeting we will establish amounts available for groceries and spending allowance as well as when and how (mail/pick-up) the person would like to receive them.

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Name: _____ County: _____

Address: _____ Phone: _____

Date of Birth: _____ SS# _____ Gender: Select _____

Contact Information:

SSA Name: _____ Phone: _____

SSA Email: _____

Other Contact: _____ Phone: _____

Email: _____ Relationship: _____

Personal Information:

Diagnosis: _____

Does the Individual have a Guardian? Select _____ (If Yes, a copy of Guardianship Papers must be attached)

If Yes: Name & Contact Information: _____

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced Children: Select _____ Number: _____

Does the Individual have ongoing court involvement/court order Select _____ (If Yes, please provide copy of current court orders)

Does the Individual have any drug/alcohol concerns? Select _____

Does the Individual receive support from any other agencies? Select

Will the agency be assisting this individual with contacting ECNWO with payee needs? Select
(If yes, please include contact information and a release of information for each agency.)

Name & Address of nearest relative: _____

_____

Does the Individual currently have a payee? Select _____ Name: _____

Why does the individual want ECNWO to become payee? _____

_____

Employment Information

Does the Individual work: Select _____ If Yes, where: _____

Rate of Pay: _____ Are checks used for expenses: Select _____ Who manages paycheck funds: _____

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Benefit Information

What type and amount of income does Individual receive:

SSI: _____ SSDI:_____ VA: _____ RR: _____ Other: _____

Medicaid Number: _____ (attach copy of card)

Medicare Number: _____ (attach copy of card)

Foodstamps: _____ Amount: _____

Does the Individual have any of the following:

Checking/Savings Account	Select	Bank Name: _____
Burial Plan	Select	Are payments being made: Select
Trust Fund	Select	
Life Insurance	Select	
Stocks/Bonds	Select	
Own a Vehicle	Select	Insurance Carrier: _____
House/Property	Select	
STABLE Account	Select	Who manages this account: _____

Monthly Expenses

Monthly Rent: _____ Date moved into home: _____

Landlord Name: _____ Phone: _____

Address: _____

Is client related to Landlord: Select Is yes, what is relationship:_____

Does the Individual receive a housing Subsidy: Select From where: _____

Please circle the utilities/expenses the Individual is responsible for:

☐Gas ☐ Water ☐ Electric ☐ Landline ☐ Cable ☐ Internet ☐ Cell

Does the Individual live alone Select (If no, Please provide names of roommates and relationship)

Name	***Relationship***

Does the Individual share expenses equally with housemates Select

Medical Information

Primary Care Physician: _____ Phone: _____

Address: _____

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Please provide us with any additional information that will be helpful to know:

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Payee Agreement

As Representative Payee of your funds, it is the responsibility of The Epilepsy Center of Northwest Ohio to establish a budget to ensure your financial needs are met. Our most important priority will be your rent and utilities payments. A meeting will be held with those that you choose to discuss your budget needs once Social Security has named ECNWO as your payee. So that we can best develop your budget, we will review all financial needs that ECNWO will be responsible for paying on your behalf, it is important that you are able to provide a list of all monthly expenses during this meeting.

As a client of ECNWO payee services, you have the right to know how your funds are being spent. A statement of your account is always available to you upon request. If you feel your financial needs have changed, you can request a new budget meeting to review and update your current budget. Your account information is confidential information and will only be released to those that you have authorized.

_____ _____

Client Signature Date

_____ _____

SSA Signature Date

Office Use Only

Signature _____ Date _____