SOCIAL SECURITY ADMINISTRATION TOE 250 Form Approved OMB No.0960-0014

REQUEST TO BE SELECTED AS PAYEE	FOR SSA USE ONLY								FOR SSA USE ONLY
	Name or Ben.Sym.	Program	DOB	Type	Gdn.	Cus.	Inst.	Nam.	
									DISTRICT OFFICE DESIGNATION
PRINT IN INK:									STATE AND COUNTY CODE:

The name of the NUMBER HOLDER: SOCIAL SECURITY NUMBER

The name of the PERSON(S) for whom you are filing (the "claimant(s)") (if different from above.) SOCIAL SECURITY NUMBER(S)

Answer item 1 ONLY if you are the claimant and want your benefits paid directly to you.

1. I request that I be paid directly .

CHECK HERE ☒ and answer only items 3,5,6 and 8 before signing the form on page 4.

I REQUEST THAT THE SOCIAL SECURITY, SUPPLEMENTAL SECURITY INCOME OR BLACK LUNG BENEFITS FOR THE CLAIMANT(S) NAMED ABOVE BE PAID TO ME AS A REPRESENTATIVE PAYEE.

2. Explain why you think the claimant is not able to handle his/her own benefits.
(In your answer, describe how he/she manages any money he/she receives now.)

☒ Claimant is a minor child

3. Explain why you would be the best representative payee. (Use Remarks if you need more space.)
The Child was court ordered into the custody of the Department of Children and Families.

4. If you are appointed payee, how will you know about the claimant's needs"

☐ Lives with me or in the institution I represent.
☐ Daily visits
☐ Visits at least once a week.
☒ By other means. Explain: Communication between Counselors and Foster Home/Care Facilities and Counselors' visits with the child.

5. Does the claimant have a court-appointed legal guardian? ☐ YES ☐ NO
IF YES, enter the legal guardian's"

NAME:

ADDRESS:

PHONE NUMBER:

TITLE:

DATE OF APPOINTMENT:

Explain the circumstances of the appointment (Use Remarks if you need more space.)

Comment [CGI1]: User Entered

Comment [CGI2]: User entered

Comment [CGI3]: Person Management: Last, First, middle initial or the child selected when launching the form; User editable

Comment [CGI4]: Checked – not user editable

Comment [CGI5]: Checked - Not User editable

Comment [CGI6]: Always

Comment [CGI7]: Checked with description. Editable

Comment [CGI8]: No Default; User Entered

6. (a) Where does the claimant live?

- ☐ Alone
- ☐ In my home (Go to (b).)
- ☐ With a relative (Go to (b).)
- ☐ With someone else (Go to (b).)
- ☐ In a board and care facility (Go to (b).)
- ☐ In a public institution (Go to (c).)
- ☐ In a private institution (Go to (c).)
- ☐ In a nursing home (Go to (c).)
- ☐ In the institution I represent (Go to (c).)

(b) Enter the names and relationships of any other people who live with the claimant.

NAME	RELATIONSHIP

(c) Enter the claimant's residence and mailing addresses (if different from yours).
Residence: Mailing: Telephone Number:

(d) Do you expect the claimant's living arrangements to change in the next year?
☐ YES ☐ NO If YES, explain what changes are expected and when they will occur. (Use Remarks if you need more space.)

7. If you are applying on behalf of minor child(ren) and you are not the parent,
Dose the child(ren) have a living natural or adoptive parent? ☐ YES ☐ NO

If YES, enter: (a) Name of parent

(b) Address of parent:

(c) Telephone number:

(d) Does the parent show interest in the child? ☐ YES ☐ NO

Please explain: **Unknown**

8. List the names and relationship of any (other) relatives or close friends who have provided support and/or show active interest with the claimant. Describe the type and amount of support and /or how interest is displayed.

NAME	ADDRESS/PHONE NO.	RELATIONSHIP	DESCRIBE SUPPORT/INTEREST

9. Check the block that describes your relationship to the claimant.
(a) ☒ Official of bank, agency or institution with responsibility for the person. Enter below which you represent:

- ☐ Bank
- ☐ Social Agency
- ☒ Public Official
- ☒ Institution:
  - ☐ Federal
  - ☒ State/Local

Comment [CGI9]: No Default; User Entered

Comment [CGI10]: No Default; User entered

Comment [CGI11]: Provider Management: Mailing address, editable

Comment [CGI12]: Provider Management: Phone number editable

Comment [CGI13]: No Default; User entered

Comment [CGI14]: No Default; User entered

Comment [CGI15]: No Default; User entered

Comment [CGI16]: Checked - Two options: 1) Public Official and State/Local for DCF Managed Trust Account 2) Institution and private Non-Profit for CBC managed Trust Accounts; Not user editable

☒ Private non-profit
☐ Private proprietary institution. Is the institution licensed under State law? ☐ YES ☐ NO

IF (a) ABOVE CHECKED, COMPLETE ONLY QUESTIONS 10 AND 11 AND SIGN THE FORM ON PAGE 4.

(b) ☐ Parent
☐ Spouse
☐ Other Relative - Specify ____
(c) ☐ Legal Representative
(d) ☐ Board and Care Home Operator
(e) ☒ Other Individual - Specify **Agent for Department of children and family**

IF (b), (c), (d), or (e) ABOVE CHECKED, GO ON TO QUESTION 12

Comment [CGI17]: Checked and answered; Not user editable

INFORMATION ABOUT INSTITUTIONS, AGENCIES AND BANKS APPLYING TO BE REPRESENTATIVE PAYEE

10. **(a) Enter the name of the institution** Florida Department of Children and Families or Legal Name of CBC

Comment [CGI18]: Defaults based on user. Not user editable

(b) Enter the EIN of the institution

Comment [CGI19]: No Default; User Entered

11. Is the claimant indebted to your institution for past care and maintenance? ☐ YES ☐ NO
If YES, give the amount of the debt, the date(s) the debt was incurred and a description of the debt. ____

Comment [CGI20]: No Default; User Entered

INFORMATION ABOUT INDIVIDUALS APPLYING TO BE REPRESENTATIVE PAYEE

12. Enter: YOUR NAME: ____

Comment [CGI21]: No Default; User Entered

DATE OF BIRTH: ____

SOCIAL SECURITY NUMBER: ____

ANY OTHER NAMES YOU HAVE USED: ____

OTHER SOCIAL SECURITY NUMBERS YOU HAVE USED: ____

13. How long have you known the claimant? ____

Comment [CGI22]: No Default; User Entered

14. Does the claimant owe you any money now or will he/she owe you money in the future? ☐ YES ☐ NO
If YES, enter the amount he/she owes you, the date(s) the debt was/will be incurred and describe why the debt was/will be incurred.
____

Comment [CGI23]: No Default; User Entered

15. If the claimant lives with you, who takes care of the claimant when work or other activity takes you away from home? What is his/her relationship to the claimant?
____

Comment [CGI24]: No Default; User entered

16. (a) Main source of your income:
☐ Employed (answer (b) below)
☐ Self-employed (Type of business: ____)
☐ Social Security or Black Lung benefits (Claim Number: ____)
☐ Pension (describe: ____)
☐ Supplemental Security Income payments (Claim Number: ____)
☐ AFDC (County & State: ____)
☐ Other Welfare (describe: ____)
☐ Other (describe: ____)

Comment [CGI25]: No Default; User Entered

(b) Enter your employer's name and address: ____

How long have you been employed by this employer? ____
(If less than 1 year, enter name and address of previous employer in Remarks.)

17. Have you ever been convicted of a felony? ☐ YES ☐ NO

Comment [CGI26]: No Default; User Entered

If YES: What was the crime? _____

On what date were you convicted? _____

If imprisoned, when were you released? _____

If probation ordered, when did/will your probation end? _____

18. How long have you lived at your current address? (Give Date MM/YY) _____
(If less than 1 year, enter previous address in Remarks.)

REMARKS: (*This space may be used for explaining any answers to the questions. If you need more space, attach a sepa rate sheet.)*

Please Direct Deposit to (Name of Fiscal Agency)
Checking Account # XXXXXXX
Routing # XXXXXX
At (bank name)

PLEASE READ THE FOLLOWING INFORMATION CAREFULLY BEFORE SIGNING THIS FORM

I understand that :

- I must use all payments made to me as the representative payee for the claimant's current needs or (if not currently needed) save them for his/her future nee ds.
- I may be held personally liable for repayment if I misuse the payments or if I am at fault for any overpayment of benefits

I agree to:

- Use the payments for the claimant's current needs and save any currently unneeded benefits for future use.
- file an account8ing report on how I used the payments when requested by the Social Security Administration.
- Notify the social Security Administration when the claimant dies, leaves my custody or otherwise changes his/her living arrangements or when I no longer have responsibility for his/her care and welfare.
- Comply with the conditions for reporting certain events (listed on the attached sheet (s) which I will keep for my records) and for returning checks the claimant is no t due.
- File an annual report of earnings if required.
- Notify the Social Security Administration as soon as I can no longer act as a representative payee or the claimant no l onger needs a payee

I know that anyone who makes or causes to be made a false statement or representation of material fact relating to a payment under the Social Security Act commits a crime punishable under Federal law by fine, imprisonment or both. I affirm that all information I have give in this document is true.

SIGNATURE OF APPLICANT	Date *(Month, day, year)*
Signature *(First name, middle initial, last name) (Write in ink)*	Telephone number(s) at which you may be contacted during the day

SIGN HERE ▶

Comment [CGI27]: No Default; User entered

Comment [CGI28]: Defaults Based on User.

Comment [CGI29]: Bank Table: Account Number

Comment [CGI30]: Bank Table: ABA number

Comment [CGI31]: Bank Table: Bank Name

Comment [CGI32]: Defaults to Current Date; Editable

Comment [CGI33]: No Default; User Entered

Authorized Agent of the Department of Children and Families

Mailing Address *(Number and street, Apt. No., P.O. Box, or Rural Route)*		
City and State	Zip Code	Name of County
Residence Address *(Number and street, Apt. No., or rural Route)*		
City and State	Zip Code	Name of County

Witnesses are required ONLY if this application has been signed by mark (X) above. If signed by mark (X), two witnesses to the signing who know the applicant 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)*

Comment [CGI34]: Provider management: Mailing address of CBC or DCF

Comment [CGI35]: Provider management: Fiscal County of CBC or DCF Office.

Comment [CGI36]: No Default; User entered