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	Section: Patient Fiscal Affairs		
	Directive: Social Security Benefits		
	Policy Owner: Office of Financial Management		

A. Policy Statement

According to Section 41.25(c) of the New York State Mental Hygiene Law, no person shall be denied care and treatment in an Office of Mental Health facility because of inability to pay related care and treatment charges.

It is the policy of the Office of Mental Health to assist patients who are potentially eligible for Social Security benefits in applying for such benefits. In addition, the Social Security Administration Representative Payee Payment Program provides assistance to persons who are unable to manage their federal benefits, permitting payment of the benefits to designated fiduciaries, referred to as “Representative Payees.”

For patients who are in receipt of Social Security benefits, the Office of Mental Health seeks to ensure that such benefits are utilized consistent with the patient’s best interests. Assessments of the needs of patients shall include their needs during the period of inpatient care and treatment, as well as anticipated needs upon discharge.

This policy directive sets forth procedures regarding the application for Social Security benefits, billing patients for the cost of their care and treatment, service by Facility Directors as patient Representative Payees, maintenance of patient discharge funds, receipt of correspondence from the Social Security Administration, and disposition of benefits upon the death of a patient.

This policy directive is applicable to all State-operated inpatient facilities.

B. Relevant Statutes and Standards

20 C.F.R. §404.2040, Use of benefit payments

Mental Hygiene Law (MHL) § 29.23, Powers with respect to property of persons receiving services

MHL § 33.07, Care and custody of the personal property of persons receiving services

MHL § 33.16, Access to clinical records

MHL § 41.25, Fees

MHL § 43.01 Fees and rates for department services

14 NYCRR Part 522, Directors of Mental Hygiene Facilities as Representative Payees

OMH Official Policy Manual Directive PC 800 - Electronic Benefit Transfer (EBT)
Card Oversight in Residential Programs
New York Social Services Law §366, Eligibility
42 U.S.C. Section 1396p(d)(4), Liens, adjustments and recoveries, and transfers
of assets
Title 2 Social Security Act, Federal Old-Age, Survivors, and Disability Insurance
Benefits

C. Definitions

1. *Chronic Care* means a type of Medicaid budgeting which begins the first day of the seventh calendar month during which time a patient remains in acute care.
2. *Discharge Reserve Account* means an account established for the benefit of an individual to facilitate his or her discharge from a facility into a less restrictive environment (e.g., for a security deposit on an apartment or utilities, the purchase of home furnishings).
3. *Exempt Social Security Benefits* means Social Security benefits which are not applied towards the cost of a patient's care and treatment. The amount of exempt benefits is calculated for individual patients, in consideration of their current financial resources and length of hospitalization, using general guidelines from the Medical Assistance program.
4. *Legal Representative* means a person who represents or stands in the place of another under authority recognized by law with respect to a patient's property (e.g., a power of attorney).
5. *Medicaid Exception Trust* means a trust that contains the assets of the beneficiary and meets the criteria set forth in 42 U.S.C. Section 1396p(d)(4) and N.Y. Social Services Law Section 366.2(b)(2)(iii), such that both the principal and income of such trust is considered exempt for purposes of determining the beneficiary's eligibility for Medicaid and/or Supplemental Security Income.
6. *Non-Chronic Care* means a type of Medicaid budgeting which is utilized during the first six calendar months while a patient is in acute care.
7. *Patient Payee* means a Social Security beneficiary who directly receives his or her own benefit payments.
8. *Qualified Person* means a qualified person as such term is defined in Mental Hygiene Law Section 33.16.

9. *Representative Payee* means a person or organization appointed by the Social Security Administration to receive and manage the Social Security benefits of another person.
10. *Social Security Benefits* means benefits paid as retirement, survivors and disability insurance pursuant to Title 2 of the Social Security Act.
11. *Windfall Payment* means a one-time payment to a patient such as a gift, an inheritance, lottery winnings, or court ordered judgment or settlement.

D. Body of Directive

This policy consists of seven components:

1. Application for Social Security Benefits
2. Payment for Care and Treatment
3. Accounting for Patient Funds
4. Determination of need for Payee
5. Facility Directors as Representative Payees for Social Security Payments
6. Windfall Payments
7. Discharge Reserve Account

DI. Application for Social Security Benefits

- (a) The Patient Resources Office, in consultation with the patient's Treatment Team, is responsible for identifying persons who are potentially eligible for Social Security benefits.
- (b) Upon such identification, it is also the responsibility of the Patient Resources Office, in consultation with the Treatment Team and the patient, as necessary and appropriate, to initiate and complete the benefit application process with the Social Security Administration.

DII. Payment for Care and Treatment

- (a) The Office of Mental Health is authorized to request payment from patients for the cost of their inpatient care and treatment. The Office must inform patients that they will not be denied care for inability to pay. All requests for payment and provision of information about failure to pay must be in writing, using Form BPR 504.
- (b) Care and treatment charges are to be assessed based on the patient's ability to pay. In assessing this ability, the Patient Resources Office shall consider all income received, including Social Security benefits, as well as assets owned by the patient.

- (c) When the Office of Mental Health establishes a billing rate for a specified patient, he or she shall be provided notice of such rate. The notice shall delineate the amount being charged, as well as the patient's monthly Personal Incidental Allowance.
- (d) If a patient makes an informed and voluntary decision to not utilize Social Security benefits to satisfy care and treatment charges, the Office of Mental Health shall not deduct such benefits from the patient's personal account or otherwise attempt to secure such funds.
 - (i) If a patient refuses to pay care and treatment charges, the Office of Mental Health may continue to bill the patient for such care and treatment. However, such bills shall not be issued more frequently than every three months. Upon written request from a patient's attorney, (e.g., the Mental Hygiene Legal Service, a private attorney, or a Protection and Advocacy office), such bills shall be sent directly to the attorney, and may be issued monthly. If a patient requests that any other communication regarding an outstanding bill for care and treatment charges be made with an attorney, and the Office of Mental Health receives this notice in writing, the Office of Mental Health shall not initiate communication with the patient regarding the bill unless the patient requests the communication.
 - (ii) If a patient subsequently agrees to pay care and treatment charges, such agreement shall be documented in writing. The Office of Mental Health shall wait for a period of two weeks from the date of agreement, after which the deduction of Social Security benefits from the patient's personal account may commence. This deduction shall be limited to those benefits obtained on and after the date of agreement, unless otherwise indicated by the patient on Form BPR 509, which identifies the options available to patients for paying future or past charges.

3. Accounting for Patient Funds

- (a) The facility business office will maintain separate patient accounting and crediting for interest earned on all funds that are deposited to the facility's Patient Cash System, and will provide an accounting for such transactions as follows:
- (b) Upon request by a patient, his or her guardian, or other qualified person, the business office will provide a statement of deposits and disbursements from the personal account of the patient on a quarterly basis. Such requests must be documented by the business office, and presented and explained to the patient, his or her guardian, or other

qualified person by a member of the patient's Treatment Team.

- (c) Deposits from federal benefits, where the Facility Director is the Representative Payee must be clearly identified in the Patient Cash System.
- (d) Expenditures for a patient's personal needs, care and treatment, burial funds, discharge reserve funds, or Medicaid Exception Trusts must be clearly identified in the Patient Cash system.

4. Determination of Need for Payee

- (a) If any member of a patient's Treatment Team has reason to believe a patient who is currently handling his or her own benefits appears to be having difficulty managing such funds, the treatment team shall meet to review the matter.
- (b) If the Treatment Team has reason to believe that the patient does not appear to be capable of managing his or her benefits, the team shall advise the patient's treating psychiatrist of this concern. The psychiatrist, or other physician designated by the Clinical Director to fulfill this purpose, shall examine the patient and assess his or her capacity to manage or direct the management of benefits in his or her own best interest. The physician shall notify the Facility Director of his or her determination.
- (c) If, based upon the physician's determination, the Facility Director has reason to believe the patient is not capable of managing his or her benefits and a Representative Payee application should be pursued, consistent with federal and state privacy laws governing the confidentiality of individually identifying health information, the Facility Director shall attempt to contact known relatives and friends of the patient who may be willing to serve as the patient's Representative Payee to determine if any are willing to serve in that role, unless the treatment team determines such contact would be clinically contraindicated.
- (d) If these efforts are not successful, the Facility Director may submit an application to the Social Security Administration for appointment to that role, consistent with the provisions of 14 NYCRR Part 522, and this policy directive.
- (e) All determinations made pursuant to this section must be documented in the patient's clinical or other appropriate record.

5. Facility Directors as Representative Payees for Social Security Payments

- (a) The Facility Director shall not apply to serve as Representative Payee for a patient who is currently handling his or her own benefits unless a physician has determined that the patient is not capable of handling his or her income in accordance with the procedures established in 14 NYCRR Part 522, and there is no other person known to the patient willing to serve in that role who can reasonably be expected to act in the patient's best interests.
- (b) When a Facility Director intends to apply to be a Representative Payee of a patient who is receiving services from the facility, the Treatment Team shall advise the patient of this determination, and shall document the discussion on form OMH 450 ADM. On behalf of the Facility Director, Patient Resources will then complete the Notice of Intent, form OMH 508i, which shall be provided to qualified persons, including the patient, consistent with federal and state laws governing the confidentiality of individually identifying health information. The Facility Director's notice of intent to apply for Representative Payee status shall be made in the time and manner set forth in 14 NYCRR Part 522.
- (c) When a Facility Director submits an application to the Social Security Administration to serve as a patient's Representative Payee (Form SSA-11), he or she shall include a list of known relatives and friends of the patient, unless the patient objects to such inclusion or it is determined by the Treatment Team to be clinically contraindicated. Individuals who have previously refused to serve as the patient's Representative Payee shall be included in this list.
 - (i) A Notice of the Facility Director's application for Representative Payee (OMH 508), shall be provided to the current payee, if any, the patient, and the Mental Hygiene Legal Service.
 - (ii) A note shall be placed in the Patient Resource file indicating the date on which the forms were sent or delivered.
 - (iii) The patient shall be advised to discuss any concerns about the application to the Social Security Administration with friends, relatives, or attorneys. The patient may also contact the Mental Hygiene Legal Service with any questions regarding the application to the Social Security Administration.
- (d) During the application process or following the appointment of a Facility Director as a patient's Representative Payee, the patient may, at any time, request to be his or her own payee, or request a change

in Representative Payee. Such request shall be directed to the Social Security Administration.

- (e) When a Facility Director is appointed as a patient's Representative Payee, the director or his or her designee shall designate the patient's Treatment Team to serve as a liaison between the director and the patient. Members of the Treatment Team shall then designate a specific position (title) on the team to serve as the patient's agent. The responsibility of such agent is to report the financial needs of the patient to the Treatment Team. This information shall be used by the Treatment Team to determine how to use Social Security benefits for the use and benefit of the patient in a manner which will serve his or her best interests.
 - (i) No member of the Patient Resources Office may serve as the patient's agent.
 - (ii) The identity of the patient's agent must be documented, by name and title, in the patient's clinical record or other appropriate location in the patient's Designated Record Set, as such term is defined in OMH policy directive QA-400, Medical Records. Such documentation must be updated whenever there is a change of agent.
- (f) As part of the overall treatment planning process, or as otherwise indicated, the patient's Treatment Team shall perform reviews every three months, to determine whether the patient's Personal Incidental Allowance is sufficient to meet his or her needs. Such reviews shall be documented in the patient's clinical record. Upon the recommendation of a patient's Treatment Team, the patient's Personal Incidental Allowance shall be adjusted accordingly.
- (g) Payments to a Representative Payee will be considered to have been expended for the use and benefit of the patient if they are used for the patient's current maintenance. This includes the customary charges made by the psychiatric center, as well as expenditures for items which will aid in the patient's recovery or release from the psychiatric center, or expenditures for personal needs which will improve the patient's quality of life/circumstances while in the psychiatric center. Any remaining amount shall be conserved or invested on behalf of the patient.
- (h) A Facility Director serving as a patient's Representative Payee shall account for the use of the patient's benefits. For facilities participating in the Social Security Administration's on-site review program, review of such accounting shall be conducted on a tri-annual basis.

- (i) When the Facility Director is appointed by the Social Security Administration as Representative Payee for a patient, and the patient receives a lump sum retroactive Social Security benefit:
 - (i) the patient's Treatment Team shall determine if expenditures should be made for personal needs which will improve the individual's quality of life/circumstances while in the psychiatric center. The Treatment Team will also determine whether a change to a patient's Personal Incidental Allowance, Discharge Reserve Account, and/or Burial Fund is needed; and
 - (ii) the Patient Resource Office will determine if the remaining funds from the lump sum Retroactive award, in combination with the patient's other resources, will cause the patient to be ineligible for government benefits. If the patient's eligibility is affected, then the Facility Director shall seek to establish a Medicaid Exception Trust, Special Needs Trust or similar device, on behalf of the individual, unless an existing trust can be used. The patient's particular circumstances will be considered when deeming it necessary or appropriate to pursue the creation of Medicaid Exception Trust, Special Needs Trust or similar device.
- (j) A Facility Director, as a patient's Representative Payee, is responsible for ensuring that the patient's Social Security benefits, including any accumulated resources, are readily available to the patient upon his or her discharge from the psychiatric center.
- (k) A Facility Director, as a patient's Representative Payee, must provide the Social Security Administration with information to enable them to complete a capability determination prior to the patient's discharge, if necessary. In the event that such information has been provided to the Social Security Administration within the past three months and there has been no significant change in the patient's condition, as determined by the Treatment Team, no further information is necessary. Information provided to the Social Security Administration shall include whether the patient:
 - (i) is dependent on drugs or alcohol;
 - (ii) is transferring to another institution, group home, or nursing home;
or
 - (iii) will be living independently.
- (l) If the Social Security Administration determines that the patient is capable of managing his or her own benefits, the Facility Director will be

removed as the Representative Payee and the patient will be appointed as his or her own payee.

- (m) If the Social Security Administration determines that the patient is incapable of managing his or her own benefits, the Facility Director shall provide an updated list of the patient's family or friends so that the Social Security Administration can expedite the location of an alternative Representative Payee. If the patient objects to the provision of an updated list or one or more names therein, or the Treatment Team determines that such action is clinically contraindicated, such list or portions thereof shall not be submitted.
- (n) If an alternate Representative Payee cannot be identified, the Social Security Administration may allow the Facility Director to continue as the Representative Payee through the end of the calendar month following the month of the patient's discharge. During this period, the Facility Director is responsible for identifying the patient's needs and making spending decisions which are in the patient's best interests.
- (o) Unless the patient is dependent on drugs or alcohol, the Office of Mental Health can, when authorized by the Social Security Administration, release the equivalent of one month's worth of benefits to the patient from his or her conserved funds in the second calendar month following the month of the patient's discharge.
- (p) Once a patient is discharged and the Facility Director is removed as the Representative Payee, the Office of Mental Health shall transfer the Social Security benefits in the patient's account to the Social Security Administration, or otherwise distribute the benefits as directed by the Social Security Administration.
- (q) Within five business days after a patient's discharge, the Office of Mental Health shall provide confirmation to the Social Security Administration that the discharge has occurred, including any administrative discharge from missing person status.
- (r) If a patient is administratively discharged from missing person status, the Social Security Administration may:
 - (i) continue Representative Payee payment to the Facility Director through the end of the calendar month following the month of the patient's discharge;
 - (ii) suspend payment if no forwarding address is available;
 - (iii) make payment to a new Representative Payee, if appropriate; or

- (iv) make direct payment to the patient if his or her whereabouts are known and he or she is capable, or if a new Representative Payee cannot be appointed within an appropriate time frame.
- (s) A Facility Director, as a patient's Representative Payee, is responsible for notifying the Social Security Administration of wages earned by the patient. Although ability to work does not automatically result in termination of Social Security benefits, and small amounts of wages do not affect eligibility for benefits, all earnings, including but not limited to those from sheltered workshops and work-for-pay programs, must be reported.
- (t) Actions taken by facility staff, or requests or objections made by patients shall be documented in forms identified for such use. Unless otherwise indicated, such forms shall not be considered to be part of the clinical record, but may be considered part of the Designated Record Set.

6. **Windfall Payments**

The Facility Director may receive a Windfall Payment on behalf of a patient, not to exceed twenty-five thousand dollars. If such funds, in combination with other funds held on behalf of the patient, would make the individual ineligible for government benefits, the Patient Resource Office shall:

- (a) if the individual has a guardian or other legal representative, the Patient Resource Office will advise the individual's guardian or other legal representative of the individual's financial situation concerning eligibility for government benefits and the option for establishing a Medicaid Qualifying Trust; or
- (b) if the patient does not have a guardian or other legal representative and the individual lacks the capacity to manage his or her own funds, the Patient Resource Office and Treatment Team may seek to establish a guardian for the patient.

7. **Discharge Reserve Account**

When determining a patient's responsibility to pay for the cost of his or her care and treatment, the Office of Mental Health will generally use the Medical Assistance (Medicaid) policy regarding chronic and non-chronic care budgeting, taking into account existing savings, as well as Social Security benefits and other income received during the patient's hospital stay. The application of non-chronic care standards for the first six months of hospitalization permits the accumulation of Social Security benefits which can

be available for discharge.

- (a) Patient Payees and non-OMH Representative Payees shall be encouraged to save funds for discharge during the first six months of the patient's hospitalization.
- (b) When a Facility Director is the patient's Representative Payee during the non-chronic care period, the Director shall establish a Discharge Reserve Account from savings accrued from exempt Social Security benefits and other income received during the first six months of hospitalization. Such account shall include a reasonable level of funds to be provided upon discharge, to meet the patient's needs in the community. The amount of funds in the Discharge Reserve Account shall be adjusted, as necessary, in accordance with any changes in the patient's discharge plan. The maximum Discharge Reserve Account shall be two thousand dollars, unless an exceptional circumstance arises such that additional monies are required in order to affect an appropriate discharge. In determining the amount of the Discharge Reserve Account to be accumulated, the Facility Director shall consider:
 - (i) the type of placement anticipated at discharge;
 - (ii) the patient's existing resources; and
 - (iii) whether the amount of the Discharge Reserve Account would jeopardize the patient's receipt of other benefit.