SOCIAL SECURITY ADMINISTRATION **TOE 250**

Form Approved
OMB No. 0960-0014

REQUEST TO BE SELECTED AS PAYEE

PRINT IN INK:

FOR SSA USE ONLY							
Name or Bene. Sym.	Program	Birthdate	Type	Gdn.	Cus.	Inst.	Nam.

FOR SSA USE ONLY

DISTRICT OFFICE CODE

STATE AND COUNTY CODE

The name of the NUMBER HOLDER	SOCIAL SECURITY NUMBER
The name of the PERSON(S) (if different from above) for whom you are filing (the “claimant(s)”)	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, BLACK LUNG OR SPECIAL VETERANS BENEFITS FOR THE CLAIMANT(S) NAMED ABOVE BE PAID TO ME AS REPRESENTATIVE PAYEE.

2. Explain why you think the claimant is not able to handle his/her own benefits.
(In you 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.)

Dakota County has financial responsibility through foster care arrangement.

4. If you are appointed payee, how will you know about the claimant’s needs?
☐ Live with me or in the institution I represent.
☐ Daily visits.
☒ Visits at least once a week.
☐ By other means. Explain:

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.)

Forward completed & signed form to: **Social Security Administration**;
190 5th Street East Suite 800; St. Paul, MN 55101-1483

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
	Foster care

(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,

Does 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? Please explain.

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
  - ☐ 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

(c) ☐ Spouse

(d) ☐ Other Relative - Specify ______________________________

(e) ☐ Legal Representative

(f) ☐ Board and Care Home Operator

(g) ☐ Other Individual - Specify ______________________________

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

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

10. (a) Enter the name of the institution **Dakota County Community Services**
(b) Enter the EIN of the institution **41-6005786**

11. Does the claimant owe you/your organization any money now or will he/she owe you money in the future?
☐ Yes ☒ No
If YES, give the amount of the debt, the date(s) the debt was incurred and the description of the debt.

INFORMATION ABOUT INDIVIDUALS APPLYING TO BE REPRESENTATIVE PAYEE

12. Enter: YOUR NAME ____
DATE OF BIRTH ____
SOCIAL SECURITY NUMBER ____
ANY OTHER NAME YOU HAVE USED ____
OTHER SSN'S YOU HAVE USED

13. How long have you known the claimant? ____

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.

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?

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 ____)

(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

If YES: What was the crime? ____

On what date were you convicted? ____

What was your sentence? ____

If imprisoned, when were you released? ____

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

Do you have any unsatisfied FELONY warrants (or in jurisdictions that do not define crimes as felonies, a crime punishable by death or imprisonment exceeding 1 year) for your arrest? ☐ Yes ☐ No

If yes: Date of Warrant ____
State where warrant was issued ____

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 separate sheet.)

PLEASE READ THE FOLLOWING INFORMATION CAREFULLY BEFORE SIGNING THIS FORM

I/my organization:

- Must use all payments made to me/my organization as the representative payee for the claimant's current needs or (if not currently needed) save them for his/her future needs.
- May be held liable for repayment if I/my organization misuse the payments or if I/my organization am/is at fault for any overpayment of benefits.
- May be punished under Federal law by fine, imprisonment or both if I/my organization am/is found guilty of misuse of Social Security or SSI benefits.

I/my organization will:

- Use the payments for the claimant's needs and save any currently unneeded benefits for future use.
- File an accounting report on how the payments were used, and make all supporting records available for review if requested by the Social Security Administration.
- Reimburse the amount of any loss suffered by any claimant due to misuse of Social Security or SSI funds by me/my organization.
- Notify the Social Security Administration when the claimant dies, leaves my/my organization's custody or otherwise changes his/her living arrangements or he/she is no longer my/my organization's responsibility.
- Comply with the conditions for reporting certain events (listed on the attached sheet(s) which I/my organization will keep for my/my organization's records) and for returning checks the claimant is not due.
- File an annual report of earnings if required.
- Notify the Social Security Administration as soon as I/my organization can no longer act as representative payee or the claimant no longer needs a payee.

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.

SIGNATURE OF APPLICANT	**DATE** (*Month, day, year*)
Signature (First name, middle initial, last name) (Write in ink) SIGN HERE	Telephone number(s) at Which You May be Contacted During the Day

for Dakota County Community Services

Print Your Name & Title (if a representative or employee of an institution/organization)

Mailing Address (*Number and street, Apt. No., P.O. Box, or Rural Route*)
1590 Highway 55

City and State **Hastings, MN**	Zip Code **55033**	Name of County **Dakota**

Residence Address (*Number and street, Apt. No., P.O. Box, or Rural Route*)

City and State	Zip Code	Name of County

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

Forward completed & signed form to: **Social Security Administration**;
190 5th Street East Suite 800; St. Paul, MN 55101-1483

JUVENILE COURT APPENDIX A

1. The Parent(s) shall use the total income and resources attributable to the child(ren) of this action for the period of care, examination, or treatment, except for clothing and personal needs allowance as provided in Section 256B.35 of the Minnesota Statutes, to reimburse Dakota County for the cost of the care, examination, and/or treatment for the child(ren). All income and resources attributable to the child(ren) for the period of care, examination and/or treatment, including child support for said child(ren), is assigned to Dakota County and shall be paid to Dakota County Community Services, 1590 Highway 55, Hastings, MN 55033 If the amount of support ordered is for two or more children and support is not set forth in a specific amount per child, the amount of assigned support for the child(ren) of this action is his/her/their pro-rata share of the total support obligation.

2. If the income and resources attributable to the child(ren), including child support, are not enough to reimburse the County for the full cost of the care, examination, or treatment, the Parent(s) shall contribute to said costs as determined pursuant to the Dakota County Fee Policy. The Parent(s) shall cooperate fully with a financial investigation, to be conducted by Dakota County Community Services Collection Unit, for the purpose of determining their parental fee and the income of the child(ren). Failure to cooperate fully shall result in the Parent(s) being obligated to pay the full cost of care for the child(ren) for each month or any part thereof that Dakota County provides for the costs of care, examination or treatment of the child(ren).

3. All reimbursement payments owing by the parents shall be subject to automatic income withholding, under Minn. Stat. §518A.53. In the event such payments are not withheld and remitted the parent is ordered to remit the same to Dakota County Community Services, 1590 Highway 55, Hastings, MN 55033.

4. Pursuant to Minn. Stat. §518A.59, notice is hereby given that section 548.091, subdivision 1a provides for interest to begin accruing on a payment or installment of support whenever the unpaid amount due is greater than the current support due.

5. No provision herein shall be deemed to restrict in any way the right of any person or political subdivision to collect arrearages pursuant to the Revenue Recapture Act for the State of Minnesota and any other similar State or Federal law.

6. If either Parent has appropriate health care coverage insurance in place or available for the child(ren), the Parent shall provide that information to Dakota County Community Services, and shall implement and/or maintain such coverage and shall cooperate with the processing of claims for the child(ren) with such coverage. "Appropriate health care coverage" is as defined in Minn. Stat. §518A.41. The parent shall execute an Assignment of Benefits for Health Coverage Form if asked to do so by Dakota County. If the parent fails to do so, this Order shall serve as authorization to enroll the child(ren) as a beneficiary in any appropriate health care coverage available to the Parent and allow for enrollment pursuant to statute. Failure to provide the Assignment shall result in the Parent being liable for the full cost of service

7. Parent(s) shall be responsible for the cost of the initial clothing allowance for the child(ren) and shall continue to be responsible for the cost of any medical care, treatment or examination of the child(ren) which is unrelated to the Court ordered treatment

8. The parent(s) shall execute a medical information release to allow various agencies of the Dakota County Community Services Division, including but not limited to, Social Services, Corrections, Public Health, the Collection Unit and Child Support Enforcement (hereinafter the County for this paragraph) to both provide to and obtain from the child(ren)'s medical provider(s) and medical/dental insurance providers medical information or insurance eligibility regarding the child(ren). If the Parent fails to do so, this Order shall serve as a medical information release authorizing the County and the medical provider(s) and the medical/dental insurance companies of the child(ren) to exchange medical and eligibility information regarding the child(ren).

9. Dakota County Community Services Agencies, including but not limited to, Social Services, Corrections, Public Health, the Collection Unit, County Attorney's Office and Child Support Enforcement may share with each other available and relevant information on the parties, participants and child(ren) in order to perform their respective duties regarding the child(ren). A copy of this Order may be provided to any agency of the Dakota County Community Services Division in order to allow them to perform their respective duties regarding the child(ren).

10. If this order requires that the child(ren) be placed out of the home through Dakota County Social Services, the custodial and non-custodial parents shall cooperate with the Dakota County Social Services Permanency Planning Specialist by providing, to the best of their abilities, names, addresses, telephone numbers, or other information needed, concerning relatives who would be contacted by the Permanency Planning Specialist as possible placement or permanent placement options. Dakota County Employment and Economic Assistance shall provide the name, address, and telephone number of the non-custodial parent to Dakota County Social Services for purposes of notifying the non-custodial parent of the placement. Dakota County Social Services shall contact all known relatives for consideration for placement, if necessary.

11. If the Court places the child(ren) with a parent (hereinafter Obligor for this paragraph) who is obligated to pay child support for such child(ren), then Obligor's child support obligation(s) for said child(ren) is/are temporarily satisfied and collection suspended, pursuant to Minn. Stat. §518A.38 for every full calendar month of court ordered placement in which Obligor provides a home, care and support for the child(ren) in Obligor's home with approval of the Court, commencing the first day of the month following placement. If the amount of support Obligor is ordered to pay is for two or more children and support is not set forth in a specific amount per child, the amount of support that is satisfied for the child(ren) is his/her/their pro-rata share of the total support obligation. This provision shall not affect Obligor's arrears payment under court order or pursuant to Minn. Stat. §518A.53 or order to provide medical/dental insurance for said child(ren).

Voluntary and Administrative Redirect Process
Presented by Lori Twitchell
Faribault & Martin Counties

Process is for children who are in foster care or with another caregiver on public assistance (MFIP, TANF, Child Care Assistance, Medical Assistance, MinnesotaCare)

Voluntary Authorization to Redirect

- Example of Letter & Form (attachment 1 & 2)
- Start date: 1st of the month following date of placement
- Termination date: 1st of the month following the end of placement

Court Ordered Redirect Language

- For any month during which the joint child(ren) is receiving foster care benefits or is receiving public assistance with a parent or relative caretaker, the child support shall be redirected to the County providing assistance to be applied to foster care or public benefits.
- COCD: Redirect information
- Start date: 1st of the month following date of placement
- Termination date: 1st of the month following the end of placement

Administrative Redirection Process

Start Redirect of Support

- Written notice must be sent to original CP and NCP
    - They have 30 days from date of notice to contest
    - The caregiver cannot contest the redirection of support
    - Don't put the support payments on hold
- Worker assigned to the case sends the following
    - F0501 – Notice of Redirect of Support to CP
    - F0500 – Notice of Redirect of Support to NCP
    - F0502 – Notice of Redirection of Support to Caregiver

  Note: If different workers assigned to cases coordinate with other workers to send notices. If original CP's case is in another county contact that county to maintain new caregiver or foster care case
- Start date: First day of the month following the expiration of the time period to contest
    - Example: Worker mails redirection notices on 3/15/13 and neither CP or NCP from the original case contest the redirection. Support continues on the original CP's case through April 30, 2013 and is redirected to the caregiver case beginning May 1, 2013.

More information under Sir Milo Redirecting Support; Administrative Redirection

Stopping Redirect of Support

- Written notice must be sent to original CP, NCP and caregiver notifying them the redirection is stopping.
- Worker assigned to the case sends the following
    - F0503 – NCP Redirection Stop Notice
    - F0504 – CP Redirection Stop Notice
    - F0505 – Caregiver Redirection Stop Notice

- Termination date: The first day of the month that occurs at least 14 days after the date that the notices are mailed to the NCP, original CP and caregiver
  - Example:
    Notices are sent March 1, 2013; the effective date is April 1, 2013
    Notices are sent March 18, 2013; the effective date is May 1, 2013
- **Note:** If the child(ren) resides with a second caregiver worker must stop the redirection on the first caregiver case, and begin the administrative redirect process on the second caregiver case.

More information under Sir Milo Redirecting Support; Stopping Redirection of Support

Contesting Administrative Redirection

- An original CP or NCP who contests the administrative process must submit a written request for hearing with 30 calendar days of the date of the notice to redirect (F0500 or F0501)
  Note: support continues to be sent to the original CP until the court orders support to be redirected to the caregiver. Do not put the support payments on hold.

More information under Sir Milo Redirecting Support; Contest of Administrative Redirection

Income Withholding

- Worker must be sure not to withhold more than 120% of the monthly support

More information under Sir Milo Redirecting Support; Enforcing the Administrative Redirection

Initiating Cases - Minnesota Order

- Worker for the original CP case provides other state with information that child is now residing with new caregiver
- Ask responding state if they require a new petition for the new Minnesota case.

More information under Sir Milo Redirecting Support; Intergovernmental Initiating Case

Responding Cases

Information under Sir Milo Redirecting Support; Intergovernmental Responding Case

Nonpublic Assistance Cases (NPA)

- With the exception of Non IV-E foster care cases, NPA cases do not meet the criteria for administrative redirection of support.

More Information under Sir Milo Redirecting Support; Nonpublic Assistance (NPA) Cases

HUMAN SERVICES

of

Faribault & Martin Counties

"An Equal Opportunity Employer"

☐ Faribault County
Human Services Center
County Office Building
P.O. Box 217
Blue Earth, MN 56013
Ph. 507-526-3265
Fax 507-526-2039

☐ Martin County Human
Services Center
115 West First Street
Fairmont, MN 56031
Ph. 507-238-4757
Fax 507-238-1574

RE:
Case #

Dear :

We have been informed that your child(ren) is/are now . Due to this change in custody, we need to redirect the child support payments to .

Please sign and date the attached "Authorization to Redirect Child Support" and return it in the attached self-addressed stamped envelope. Please note if you fail to return this authorization we will be forced to start a court action against you to get the child support redirected.

Thank you in advance for your anticipated cooperation and prompt response.

Sincerely,

Lori Twitchell
Child Support Supervisor

Attachment

Attachment 1

That I, , hereby assign to Human Services of Faribault & Martin Counties or other caregiver, the monthly child support payments that are received from for the support and care for the minor child(ren): .

That the assignment shall be effective on , and will continue for as long as the minor child(ren) is/are in the care and custody of Faribault & Martin Counties or other caregiver. Any arrears that accrue during this time period will be owed to the appropriate assignee.

That if this document is not signed, the child support will be sent to me per the child support order. However, the county may determine the support paid to me was misdirected and require I repay any money that was sent incorrectly following receipt of an order for redirection.

______________________________ ______________

Name Date

______________________________ ______________

Human Services of Faribault & Martin Counties Date

Original to IV-D File: ( )
cc: Social Services/Mental Health ( ) Parental Fee File ( )

Attachment 2