United States of America
Railroad Retirement Board

PROPOSED

Form Approved
OMB No. 3220-0052

Statement Regarding Patient's Capability to Manage Benefits

RRB Claim Number:

Employee's SS Number:

Employee's Name:

Beneficiary's SS Number:

Beneficiary's Name:

Physician/Medical Officer Name, Address, and Telephone Number	RRB Information
Telephone Number:	Office Number: Date Released: U. S. RAILROAD RETIREMENT BOARD <Office Name> 844 North Rush Street Chicago, IL 60611-**1275**

Paperwork Reduction Act and Privacy Act Notices

This report is authorized by Section 7 of the Railroad Retirement Act, as amended (45 U.S.C. 231f). While you are not required to respond, your cooperation will help us decide whether any railroad retirement benefits that may be due should be paid directly to the patient or to someone else on the patient's behalf. Although we cannot reimburse you for your services, your cooperation in completing and returning this statement will be appreciated. Please answer all items as completely as possible. If you need more space, you may use Item 8 for this purpose. For your convenience we have enclosed an envelope requiring no postage.

We estimate this form takes an average of 6 minutes per response to complete, including the time for reviewing the instructions, getting the needed data, and reviewing the completed form. Federal agencies may not conduct or sponsor, and respondents are not required to respond to, a collection of information unless it displays a valid OMB number. If you wish, send comments regarding the accuracy of our estimate or any other aspect of this form, including suggestions for reducing completion time to Chief of Information Resources Management, Railroad Retirement Board, 844 N. Rush St., Chicago, Illinois 60611-**1275**.

Patient Name and Address

1.

Physician's Statement

2. Provide the date of your most recent examination.

Month Day Year

3. In your opinion, is the patient able to manage benefit payments in the patient's best interest?

☐ Yes -- Go to Item 9

☐ No -- Go to Item 4

NOTE: *The ability to manage benefit payments in the patient's best interest is the ability to understand and act on the ordinary affairs of life, such as providing for one's own adequate food, housing, clothing, etc., and the ability, in spite of physical impairment, to manage funds. The physical ability to endorse checks is not sufficient to indicate the ability to manage benefit payments.*

4. Do you expect the patient to recover sufficiently to handle benefit payments in the patient's best interest?

☐ Yes _____
Expected date of recovery

☐ No

☐ Undetermined

5. Describe the medical condition(s) which impair(s) the patient's ability to manage benefit payments. If you need additional space, continue in Item 8.	
6. Has anyone assumed responsibility for the patient's welfare?	☐ Yes -- Go to Item 7 ☐ No -- Go to Item 9
7. Name	Number and Street, P.O. Box, or Rural Route
City and State	ZIP Code
Area Code | Telephone Number	

Relationship to patient:
- ☐ Spouse
- ☐ Relative _____ (Specify relationship)
- ☐ Legal Guardian
- ☐ Other _____ (Specify)

8. Remarks

9. **Certification**

I certify that the information I have given is true, complete, and correct. I understand that criminal or civil penalties may be imposed on me for false or fraudulent statements.

_____ _____

Physician's/**Medical Officer's** Signature Date

_____

Physician's/**Medical Officer's** Name **and Title**
(Please Print)