Change of Events – Representative Payee Reporting Form

Date: _____

To: Social Security Administration Phone:

Fax:

Name of Beneficiary: _____

SSN: _____

Please check the appropriate box:

- ☐ Beneficiary died.
  Date of death: _____
- ☐ Beneficiary discharged/or left your custody.
  Date of discharge/left: _____
- ☐ Beneficiary's new address
  _____
  _____
  _____
- ☐ Beneficiary entered the hospital.
  Date of admission: _____
- ☐ Beneficiary discharged from hospital.
  Date of discharge: _____
- ☐ Discharged to (if known): _____

_____
Print name of person completing form and title

_____ _____
Signature of person completing form Date

525 N. Martin Luther King Blvd. Tallahassee, FL 32301 (850) 410-1020 fax: (850) 410-1076
www.bigbendcbc.org