children & families of iowa
Restoring hope. Building futures. Changing lives.

THE PROCESS:

Complete all applicable fields on **ALL** documents with the Client.
*If all fields are not completed, the application will not be able to be processed with SSA.

Please ensure that the application is legible.

Client or Guardian (if applicable) will need to sign all documents as stated.

- **If the Client has a Guardian: CFI needs the following information turned in with the application. SSA will not proceed without Guardianship paperwork.**
  - SSA requires:
    - a copy of the Guardianship papers (**must show appointment date**).
    - Guardian's address
    - Guardian's phone number

- Form SSA-787 is **required** and must be **completed by the Client's mental health doctor**. Ensure the **Client's name AND Social Security Number are on the form and that the doctor includes diagnoses and reason payee is needed.** (If these details are not included, the 787 will be rejected. This will hold up the application process.)

- **The Doctor's office needs to fax the *attached* SSA 787 directly to SSA at 1-833-950-3567, attention CFI PAYEE APP for 'CLIENT NAME'**
  - **PLEASE fax copy to CFI – 515-288-9109**

Once the forms are completed and returned to CFI the application will be completed with SS on the next application date. CFI has a standing application appointment every 3 weeks.

***Please note that once the application is completed with SS the process takes at least 45-60 days. CFI does not always receive letters before funds arrive or receives a letter and no funds arrive. CFI will not be able to confirm that we have become payee until funds actually arrive at CFI for the client.

Information Required Prior to Receiving funds:

- **Copy of Rent or Lease Agreement-**
- **Housing assistance information**
- **Copies of All Current and Past Due Bills**
- **Copies of Fines or Fees owed to the State or the County**
- **Medical Bills**
- **Phone Bill**
- **Utility Bills**
- **Clients need to give notice** to **ALL** companies they owe and Change their billing address **to CFI address:**

  Client's Name
  1111 University Ave, Room F
  Des Moines, IA 50314

How Does the client wish to receive spending money?

Checks – Client will need to come to the office each pay day to pick up spending money checks. Clients will need to keep and turn in **ALL** receipts (this is a requirement per Social Security).

Debit card- We work with True Link Financial to disburse funds via a debit card. True Link charges a $4 monthly fee for the debit card services. The client is required to pick their card up in person. Once they receive their card, spending funds will load automatically on payday or days chosen. Keeping receipts is not required when using the debit card as the card transaction list serves as the receipt and we send this out quarterly to be signed by the client. **Note**: There is not an option for cash back when choosing the card. If cash is needed for a specific reason this can be discussed.

Cost of Services:

In 2024 the cost for payee services is $54.00 per month. This increases by $2 each year with the cost-of-living increase.

children & families of iowa Protective Payee Services

Social Security Review & Client Registration Form [This form needs to be thoroughly completed]

Client Name: _____ **Social Security #:** _____

DOB: _____ **Place of Birth:** _____**Mother's Maiden Name**_____

Primary Language Spoken: _____ English Proficient? _____

Current Address: _____ **City/State/Zip**_____

Previous Address: _____ **City/State/Zip**_____ **Date Moved**_____

Plans to Move Within 6 months: Y__ N__ Date:_____ **Address:**_____

Current Cell Phone #: _____ **House Phone #:** _____

Does Client currently have a Payee? Yes _____ No_____ If yes, who is Current Payee? _____
Guardian(s) Yes ____ No_____ **If yes, CFI MUST have a copy of guardianship papers and info to complete the application with SS.**

Guardian(s) Name: _____ **Address:** _____ **City/State/Zip**_____

Phone: _____ **Email:** _____

WOULD CLIENT LIKE TO RECEIVE SPENDING MONEY VIA CHECK (requires in office pick up and all receipts to be kept) _____
OR DEBIT CARD (transaction list will serve as receipt and will need sign quarterly) _____

LIVING ARRAGNMENT:

____ Alone _____With Roommates _____ # of Roommates _____ Spouse/Significant Other ____ With Relative

____ Residential Facility/Provider? _____ Host Home/Provider? _____

____ Group Home/Provider? _____ Other _____

Emergency Contact Name: _____ **Phone:** _____

Address: _____ **City/State/Zip:** _____

Case Manager/ Name: _____ **Agency:** _____

Phone#_____ **Email:** _____ **Title:** _____

Provider/ Name: _____ **Agency:** _____

Phone#_____ **Email:** _____ **Title:** _____

Housing Staff/ Name: _____ **Agency:** _____

Phone#_____ **Email:** _____ **Title:** _____

SSA-787 INFORMATION: Note Dr office needs to Fax SSA-787 directly to SS at 1-833-950-3567
Attn: CFI PAYEE APP for 'CLIENT NAME' (ENSURE FORM INCLUDES CLIENTS SS# AND DIAGNOSIS)
(please include Dr. information below to share with SS at the time of application)

Clinic Name: _____Phone: _____Name of Dr: _____

Address: _____ City: _____ State: ____ Zip Code: _____

children & families of iowa Protective Payee Services

Social Security Review & Client Registration Form [**Answer All That Apply**]

Client Demographic Information

Gender: ___ Male ___Female ___Other

Race (select all that apply): __ White __ Black/African American __ Bi/Multi-Racial __ Hispanic __ Asian

__ Alaskan Native/American Indian/Native Hawaiian/Other Pacific Islander __ Other

Ethnicity: __ Hispanic/Latino __ Non-Hispanic/Latino

Marital Status: ____ Single ___ Divorced ___ Married ___ Domestic Partner ___ Widowed ___ Separated ___ Minor

---

Employment Status: __ Employed __ Unemployed __ Retired __ Student __ Part Time __ Minor

Current Employer: _____ Paystubs turned in: Mailed__ Faxed __ Brought In: __ Use App: __

- **___ Other Type of Income, from where _____**

In the previous 12 months, did the following occur for 30 continuous days?

- **___ Hospitalized, Location? _____**
- **___ In Jail**
- **___ None of the Above**

Personal Bank Name: _____ Account Balance $ _____ [Send/Bring in Statements]

SSI Income: $_____ SSDI Income: $_____ Wages Only: $_____ Receive Food Stamps: __/Amt: $_____

Benefit Waiver/Stay below $2k __/What? _____ Railroad Benefit? __/Amt: $_____

Military VA Benefit? __/Amt: $ _____ Trust Fund: __/Balance? $_____ Life Insurance: __/ Payment Amt: $_____

Housing Assistance__/Provider? _____

Burial Account/ Prepaid Funeral? __/Location: _____/Payment Amt: $_____

Own Real Estate? __/Address: _____ Own a Car:___ /Year-Make-Model:_____

Own any valuables worth $1,000 or more? _____/What? _____

Own stocks or investments? __/ Where? _____

Own Savings Bonds? __/Value: $_____ Pay or Receive Child Support or Alimony? __/Amount: $_____ Annually

Name Other Household Members or Others with significant involvement:

Name	Date of Birth	Gender	Relationship to Client	Lives in Household

Form completed by: _____ Date: _____

Consent for the Release of Confidential Information

Name: _____ **Date of Birth:** _____ **Social Security Number**: _____

I authorize **Children & Families of Iowa (CFI)**, **Protective Payee Services** to:

[X] Release Information To AND/OR
[X] Obtain Information From

Organization Name: _____ Department or Service: _____
Individual Name: _____ Address: _____
City: _____ State: _____ Zip Code: _____ Phone Number: _____

Electronic Communication (mark box to indicate your response):

[X] I provide permission for electronic transmission/transfer of confidential information to the above designated organization/individual.
[ ] I do **NOT** provide permission for electronic transmission/transfer of confidential information to the above designated organization/individual.

Specific Type of Information to be Disclosed (mark the box next to the appropriate categories):

[ ] Legal history/criminal justice status
[ ] Medical history
[ ] Discharge summary
[ ] Education information
[ ] Date and time of attendance/no shows
[ ] Attendance/progress in treatment/treatment plan
[ ] Assessment information/testing results/evaluation/referral recommendation(s)
[X] **Other** (specify): information related to housing and other expenses, social security and other benefits

The purpose for this Release is (mark the box next to the appropriate categories):

[ ] To monitor/follow through with referral
[ ] Collaboration with treatment
[ ] Case consultation
[ ] Share assessment information, referral recommendation(s), and following through with referral
[X] **Other** (specify): assist client with financial needs

Consent for the Release of Protected Information: I understand that my alcohol and/ or drug treatment records are protected under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 C.F.R Part 2, and Health Insurance Portability and Accountability Act of 1996 (HIPAA), 45 C.F.R, pts, 160 & 164, and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it by providing CFI's Privacy Officer with written notification. **This consent automatically expires 90 days after the consent form is signed for a one-time release of information or one year when required for ongoing service provision.** By **initialing** below, I indicate that I understand the above and agree for the following information to be released:

[ ] Mental/Behavioral Health
[ ] Substance Abuse
[ ] Developmental Disability
[ ] HIV/AIDS Status/Information
[X] Other (specify): PROTECTIVE PAYEE SERVICES

CFI may not condition services on signing this authorization except if the only reason CFI is providing you with services is to make a report to a third party, such as the legal system. By following the steps noted in CFI's policies regarding your right to inspect your record, you may inspect or copy the health information disclosed. CFI may assess a reasonable fee for copy services. A copy of this form will be offered to you. By signing below, I attest that I understand the information presented to me and am voluntarily providing my consent for the information indicated above to be released.

X_____ X_____
Client Signature Date

X_____/_____ X_____
Guardian or Legal Representative Signature **Relationship to Client** Date

X_____ X_____
Witness Signature (CFI) Date

_____ _____

[ ] **CLIENT, GUARDIAN, or LEGAL REPRESENTATIVE REFUSED TO SIGN: Witness Signature** Date

Prohibition of Redisclosure: Mental health and alcohol/drug abuse information that is disclosed from records are protected by federal and state laws and requirements which prohibit further disclosure without the specific written consent of the patient, or as otherwise permitted by such law and/or regulations. Other information that is disclosed as permitted by this authorization may be re-disclosed by the recipient of the information and may no longer be protected by federal and state laws.

I, _____, **revoke my consent for the release of confidential information on this date**:_____
Client, **Guardian,** or Legal Representative Signature

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Financial Agreement

Client Name:_____ Date of Birth (MM/DD/YY):_____

Please carefully read the following and ask questions to Children & Families of Iowa staff before signing below.

I understand that in the case that the County or another funder does not cover the cost of the monthly **Protective Payee Services** provided by Children & Families of Iowa, I will be charged and pay $54.00 per month for services.
This fee will be charged to the account as a service fee paid to Children & Families of Iowa**. In 2024 the fee amount of $54.00 has been set by the Social Security Administration and is subject to change annually.** Children & Families of Iowa will notify the client when the rate changes.

Should the County or another funder retroactively cover the fee for Payee Services provided by Children & Families of Iowa, the **$54.00 charged by CFI will be repaid back** to the client's account.

I authorize Children & Families of Iowa to verify my eligibility for covered benefits and services with the County or other funders.

Client Signature: X_____

Guardian/Legal Representative Print Name: X_____

Guardian/Legal Representative Signature: X_____

Protective Payee Staff Initials: X_____ Date: X_____

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Intake Checklist and Consent to Participate – Protective Payee Services

Welcome to Children & Families of Iowa's Protective Payee Services. The following information will provide you with an overview of the policies and procedures we have used to best serve our clients. If at any time during your participation questions arise regarding any aspect of the policies and procedures, please do not hesitate to contact your payee or the Program Supervisor, Tami Masters at 515-697-7977 or tamim@cfiowa.org.

Please mark the boxes indicating that you have read and understood the information in each paragraph. Your review of the following is good for the length of time you participate in Protective Payee Services. You may request to review this documentation again at any time during your services. Review of this document is required at each re-admission of the program.

➢ Goals of the Program

Children & Families of Iowa's Protective Payee Services helps individuals and families so they can live as independently as possible and work toward self-sufficiency by managing their finances.

➢ Funding Source for Services

The Protective Payee Services program follows the guidelines established by the Social Security Administration (SSA). The SSA sets the standards as well as the monthly fee CFI is allowed to charge the clients. Some clients qualify for a Notice of Decision, where the monthly fee is paid by another agency.

➢ Notice of Privacy Practices

Please carefully review the Notice of Privacy Practices, which describes how medical information about you may be used and disclosed and how you can get access to this information.

I acknowledge that I was offered and reviewed a copy of Children & Families of Iowa's HIPAA PRIVACY NOTICE which identifies the ways my Protected Health Information (PHI) may be used and disclosed and states my rights with respect to my PHI.

X_____/X_____

Signature of Client/ Guardian or Legal Representative

➢ Rights & Responsibilities of Clients

Please carefully review the document detailing your rights and responsibilities as a client. A clear understanding of your right to safe, fair, and quality treatment and your responsibility to attend treatment regularly and follow our policies will help us serve you better. Please read this carefully and direct any questions to your assigned payee.

I acknowledge that I was offered and reviewed a copy of Children & Families of Iowa's Client Rights & Responsibilities document which identifies my rights and the program's expectations of me.

X_____/X_____

Signature of Client/Guardian or Legal Representative

➢ Termination of Services

If you can no longer be served at Children & Families of Iowa for any reason, we will contact the Social Security Administration to notify them of termination of services. Protective Payee Services may be terminated voluntarily, if another service or individual is selected to provide payee services, if Social Security benefits end, or upon non-compliance with Protective Payee Services policies.

➢ Confidentiality

You may be asked to sign a consent form for the release of confidential information to specific agencies, companies, or individuals to allow us to collaborate on your behalf. Unless such communication is court ordered, you will always be able to deny or revoke this consent. Signed releases of confidential information are considered valid for one year, upon your signature to revoke, or upon your discharge from the program, whichever occurs first.

➢ Grievance Procedures

If you have any concerns about the quality of services that are being provided to you, you can request a formal grievance form from the from desk in the main lobby at 1111 University Ave or contact the Program Supervisor at 515-697-7977. Our full grievance policy is also posted at each CFI location.

I acknowledge that I was offered and reviewed a copy of Children & Families of Iowa's Grievance Process Policy which outlines the process for filing and handling of client grievances.

X_____/X_____

Signature of Client/ Guardian or Legal Representative

➢ Content of Client Files

Your file contains intake paperwork, ongoing updates, and assessments as necessary, and notes about ongoing contact. This file may be contained electronically, in paper form, or both. The contents of your records are confidential and are only available to program staff and CFI administrative staff as needed.

➢ Procedure to Review Client Files

You may request copies of information contained in your client file. These requests will be reviewed and action to be taken will be determined by your payee and/or the Program Supervisor. There may be a reasonable fee for copies which will be determined by the Business Office.

➢ Client Satisfaction Survey

We ask for your help in improving our services by evaluating your experience at Children & Families of Iowa. You may be asked periodically to complete surveys regarding your services. While your feedback is greatly appreciated, it is always optional to complete the agency Satisfaction Surveys. Your feedback is always kept anonymous.

➢ Mandatory Child and Adult Abuse Reporting

Please be aware that staff at Children & Families of Iowa are mandatory reporters of child and adult abuse. If we see or hear information that suggests there may be risk of harm to a child or an adult, we are mandated by the state of Iowa to report that information to the Iowa Department of Human Services.

➢ Electronic Communication

If at any time you consent to communication via email, text, video conference, or other electronic means from CFI staff, please be aware of the risks of sharing confidential information in such a manner. CFI's systems are HIPAA compliant, and we make every effort to protect the privacy of all clients; however, there are still risks involved with using such means of electronic communication. If you have any questions about the use of electronic communication and the safeguards in place, please contact your payee or the Program Supervisor.

➢ Contact and Personal Information

To ensure we can contact you, please notify your payee anytime your address, phone number, or email address change. If we are unable to contact you after a period, we may discharge you from our services.

The preceding information has been presented to and reviewed with me as indicated by a mark in each box. I understand the preceding information and I consent to participate in the Protective Payee Services program. I understand the risks and benefits of participation and the possibility that I may not reach my service goals.

X_____ X_____

Client's Signature Date

X_____ X_____

Guardian or Legal Representative Date

X_____ X_____

CFI Staff Date

CONTRACT FOR PAYEE SERVICES

children & families of iowa
Protective Payee Services

I have discussed my needs with _____ (PPS staff). I agree to have Children & Families of Iowa serve as representative payee for SSDI and/or SSI payments.

I will:

- Be clean and sober when in office to conduct business, Monday-Friday between 9AM and 3PM
- Treat staff with courtesy and respect
- Keep spending within the budget set with the Payee
- Sign a receipt when to receive a check or debit card for personal spending
- Sign and confirm monthly spending list for the Debit Card used
- Obtain and submit receipts for spending checks received
- Report all income (including rent rebates, part time jobs, any payment in cash, etc.), and
- Report any changes (new address, new phone number, hospitalizations, start or stop of employment)
- Change the billing address of all bills that CFI will assist in paying
- Contact the payee in case of a financial emergency

Children & Families of Iowa will:

- Treat clients with respect and courtesy
- Be available Monday-Friday between 9AM and 3PM (except on holidays)
- Return calls and/or correspondence within 24hrs
- Use client benefits to meet their current needs for food, housing, clothing, and medical, etc....
- Report to Social Security Administration (SSA) any events that may affect eligibility for benefits
- Report to SSA how money has been spent or saved
- Save and report any unspent funds
- Return any saved funds due to termination of services, or due back to the Social Security Administration

By signing below, I agree to and understand the terms listed above. If either party is non-compliant with the above, services may be terminated.

X_____ X_____
Client's Signature Date

X_____ X_____
Guardian or Legal Representative Date

X_____ X_____
CFI Staff Date

X_____ X_____
Case Manager Date

Edited 1.25.23
Edited 1.11.24

Children & Families of Iowa

Representative Payee Department

Debit Card Consent Form

Date:_____

First Name:_____

Last Name: _____

Date of Birth: _____

I have chosen to obtain the True Link debit card. I have received the fee schedule for this service. I understand and accept the monthly fee of $4.00 and all fees associated with this card. It is legally and entirely my choice to make the purchase of this service with my personal funds allowance, and I am exercising my right to do so. My consent is effective from today through **January 31st, 2025**. I will review this consent annually thereafter.

There are no fees being charged for this card by Children & Families of Iowa. All fees are being charged by True Link Financial. The card agreement is between myself and True Link Financial.

I understand that I can withdraw this consent at any time, for any reason, by contacting my Representative Payee and requesting my card services be cancelled.

Client Name (print):_____

Client Signature: _____Date:_____

Guardian Name (print): _____

Guardian Signature:_____ Date: _____

FMS Manager Name: _____

FMS Manager Signature: _____Date:_____

Medical Source Opinion of Patient's Capability to Manage Benefits

	In replying, use this address: SOCIAL SECURITY ADMINISTRATION
	TELEPHONE NUMBER (Including Area Code)
	DATE
	SSA CONTACT

IDENTIFYING INFORMATION (SSA Only)
If different from patient

NAME OF WAGE EARNER OR SELF-EMPLOYED PERSON	SOCIAL SECURITY NUMBER

PATIENT'S NAME

PATIENT'S SOCIAL SECURITY NUMBER	PATIENT'S DATE OF BIRTH

PATIENT'S ADDRESS (Number and Street, City, State, and ZIP Code)

YOUR HELP IS NEEDED

The patient shown above has filed for or is receiving Social Security or Supplemental Security Income benefits. We need you to complete the back of this form and return it to us in the enclosed envelope to help us decide if we should pay this person directly or if he or she needs a representative payee to manage the Social Security Administration (SSA) benefits on his or her behalf.

Please Note: This determination affects how benefits are paid and has no bearing on disability determinations. Unfortunately, SSA cannot compensate you for the time it takes to provide this information. Thank you for your help.

WHAT IS A REPRESENTATIVE PAYEE

A representative payee is someone who manages the patient's SSA benefits to make sure the patient's basic needs are met. The payee has a strong and continuing interest in the patient's well-being and is usually a family member or close friend.

WHO NEEDS A REPRESENTATIVE PAYEE

Some individuals age 18 and older who have mental or physical impairments are not capable of managing their SSA benefits or directing others to manage them to meet their basic needs, so we select a representative payee to receive their benefits on their behalf. Examples of impairments that may cause incapability are dementia, brain damage or chronic schizophrenia. However, a person's need for some assistance with financial tasks such things as bill paying, etc., does not necessarily mean he/she cannot make decisions concerning basic needs and is incapable of managing his or her own benefits. If the individual is able to direct the management of his or her own benefits, then we will consider the individual capable.

PLEASE COMPLETE THE INFORMATION ON THE REVERSE OF THIS FORM

PATIENT'S NAME

PATIENT'S SOCIAL SECURITY NUMBER	PATIENT'S DATE OF BIRTH

PATIENT'S ADDRESS (Number and Street, City, State, and ZIP Code)

1. Date you first saw the patient _____

2. Date you last saw the patient _____

3. How many times have you seen this patient? _____

4. Are you able to assess the patient's ability to manage or direct the management of funds? ☐ Yes ☐ No

   If no, please skip the remaining questions and sign and date the form

5. What is the basis for your assessment (e.g. observation, medical records, diagnostic tests, patient's self-report, family member's report)?

Note: Please keep in mind in responding to the following questions that the actual performance of the patient, when known, is usually the best indicator of the patient's abilities.

6. Does the patient:

   - Have a general understanding of his or her finances (i.e., income, assets, expenses)? ☐ Yes ☐ No ☐ Unknown
   - Have sufficient ability to handle a checking/savings account? ☐ Yes ☐ No ☐ Unknown
   - Have sufficient ability to pay bills in a timely manner? ☐ Yes ☐ No ☐ Unknown

7. Can the patient successfully manage or direct the management of funds to meet basic needs (e.g. food, clothing, shelter)?

   ☐ Yes
   If "Yes," please provide a brief summary of the findings that led to this conclusion, and complete question 8. Please also sign and date the form.

   ☐ No
   If "No," please provide a brief summary of the findings that led to this conclusion, and complete question 8. Please also sign and date the form.

   ☐ Unsure
   If "Unsure," please explain and sign and date the form.

8. Do you expect the patient to be able to manage or direct the management of his or her benefits in the future (e.g. the patient is temporarily unconscious)?

☐ Yes ☐ No

Please explain your answer.

NAME OF MEDICAL SOURCE (Please print.)	TITLE
ADDRESS (Number and Street, City, State, and ZIP Code)	TELEPHONE NUMBER (*Include Area Code*)

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. I understand that anyone who knowingly gives a false statement about a material fact in this information, or causes someone else to do so, commits a crime and may be subject to a fine or imprisonment.

SIGNATURE OF MEDICAL SOURCE	DATE

Privacy Act Statement
Collection and Use of Personal Information

Sections 205, 807, and 1631(a) of the Social Security Act, as amended, allow us to collect this information. Furnishing us this information is voluntary. However, failing to provide all or part of the information may prevent us from making a determination regarding the beneficiary's capability or inability to handle his or her own benefits.

We will use the information to determine the beneficiary's need for a representative payee. We may also share your information for the following purposes, called routine uses:

- To Federal, State, or local agencies for administering cash or non-cash income maintenance or health maintenance programs; and

- To contractors and other Federal agencies, as necessary, for the purpose of assisting the Social Security Administration in the efficient administration of its programs.

In addition, we may share this information in accordance with the Privacy Act and other Federal laws. For example, where authorized, we may use and disclose this information in computer matching programs, in which our records are compared with other records to establish or verify a person's eligibility for Federal benefit programs and for repayment of incorrect or delinquent debts under these programs.

A list of additional routine uses is available in our Privacy Act System of Records Notices (SORN) 60-0089, entitled Claims Folders Systems, as published in the Federal Register (FR) on April 1, 2003, at 68 FR 15784, and 60-0222, entitled Master Representative Payee File, as published in the FR on April 22, 2013, at 78 FR 23811. Additional information, and a full listing of all our SORNs, is available on our website at www.ssa.gov/privacy.

Paperwork Reduction Act Statement - This information collection meets the requirements of 44 U.S.C. § 3507, as amended by section 2 of the Paperwork Reduction Act of 1995. You do not need to answer these questions unless we display a valid Office of Management and Budget control number. We estimate that it will take about 20 minutes to read the instructions, gather the facts, and answer the questions. **SEND OR BRING THE COMPLETED FORM TO YOUR LOCAL SOCIAL SECURITY OFFICE. You can find your local Social Security office through SSA's website at** www.socialsecurity.gov**. Offices are also listed under U.S. Government agencies in your telephone directory or you may call Social Security at 1-800-772-1213 (TTY 1-800-325-0778).** *You may send comments on our time estimate above to: SSA, 6401 Security Blvd, Baltimore, MD 21235-6401.* ***Send only comments relating to our time estimate to this address, not the completed form.***