



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 ARRANGMENT:

____ 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:

Table with 5 columns: 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:

- Release Information To AND/OR
 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):

- 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 Discharge summary Date and time of attendance/no shows
 Medical history Education information Attendance/progress in treatment/treatment plan
 Assessment information/testing results/evaluation/referral recommendation(s)
 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
 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 **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



children & families of iowa 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 _____



children & families of iowa 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 front 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 _____
Client’s Signature

X _____
Date

X _____
Guardian or Legal Representative

X _____
Date

X _____
CFI Staff

X _____
Date

CONTRACT FOR 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 _____
Client's Signature

X _____
Date

X _____
Guardian or Legal Representative

X _____
Date

X _____
CFI Staff

X _____
Date

X _____
Case Manager

X _____
Date