children & families of iowa
Protective Payee Services

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'.**

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.

CHECKLIST:

Was the 787 faxed with SS# on form to SS from your Doctor's office? Yes❑ No❑

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 this helps to locate the 787 that was faxed)

Clinic Name: _____ Phone: _____ Name of Dr: _____

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

Bill Information

- **What amount does the client pay in rent $**_____
- **Where is rent to be sent** _____
  Please provide a copy of the signed lease or rental agreement.
- **Does the client receive housing assistance?** Yes❑ No❑
  Amount paid by assistance $_____ **and what funding source?** _____
  Please provide a copy of the award amount from housing assistance.

Does the client pay for:

Pharmacy Yes❑ No❑ Vender Name_____
Electric Yes❑ No❑ Vender Name_____
Gas Yes❑ No❑ Vender Name_____
Water Yes❑ No❑ Vender Name_____
Internet/Cable Yes❑ No❑ Vender Name_____
Insurance (renters, car, homeowners) Yes❑ No❑ Vender Name_____
Health Insurance Premiums (Cigna- Humana etc.) Yes❑ No❑ Vender Name_____
Landline Yes❑ No❑ Vender Name_____
Cell Phone Yes❑ No❑ Vender Name_____
Credit Card Yes❑ No❑ Vender Name_____
Other Yes❑ No❑ Vender Name_____

PLEASE NOTE: prepaid phones and/or subscription services such as Hulu, Roku, Netflix etc. will need to be figured into the client's budgeted spending money and it will be the RESPONSIBILITY OF THE CLIENT TO PAY.

- **Does the client have Fines?** Yes❑ No❑ Vender Name_____
  Copies needed of Fines or Fees owed to the State or the County
- **Does the client have Medical Bills** Yes❑ No❑ Vender Name_____
- **Does the client have a Bank Account?** Yes❑ No❑ Vender Name_____
- **Does the client have prepaid Burial Arrangements?** Yes❑ No❑ Vender Name_____
- **Does the client have Other Assets?** Yes❑ No❑ Vender Name_____
- **Does the client have MEPD?** Yes❑ No❑
  If yes, does the client owe a monthly premium? Yes❑ No❑ Amount $_____

Clients need to give notice to **ALL** the companies they owe and change their billing address **to CFI address**:

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

COST OF SERVICES:

In 2025 the cost for payee services is $55.00 per month. This increases by $2 each year with the cost-of-living increase.

How Does the client wish to receive spending money? Please choose one:

❑ **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 **$5.00 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.

List of all fees for True Link Independence Visa®Prepaid Card ("List of All Fees") Page 1 of 1

Fee	Fee Description Online/Statement	Fee Amount	Details
Set-Up and Maintenance REGULAR DEBIT			
Monthly Fee	Monthly Fee	$5.00	This fee will be charged on the first day of the month following card activation, and monthly thereafter.
Set-Up and Maintenance MONITORED SPENDING CARD			
Monthly Fee	Monthly Fee	$8.00	This fee will be charged on the first day of the month following card activation, and monthly thereafter.
Information			
ATM Balance Inquires	Balance Inquiry Fee	$0.50	This is our fee charged for checking your balance at an ATM. The ATM operator may also charge a fee. To avoid this fee, check your balance for no charge on our website, www.truelinkcard.com, or call 1-800-299-7646 and use the automated telephone system.
Other			
Replacement Card	Replacement Card Fee	$5.00	This is our fee each time you request a replacement card prior to the expiration/valid thru date of your card.
Expedited Card	Expedited Shipping Fee	$30.00	This is our fee each time you request expedited shipping for a card. Your card will arrive in approximately 2-4 business days. You can choose standard delivery for your card for no shipping fee.

Your funds are eligible for FDIC insurance. Your funds will be held at or transferred to Sunrise Banks N.A., an FDIC-insured institution. Once there, your funds are insured up to $250,000 by the FDIC in the event the Bank fails, if specific deposit insurance requirements are met and we have been able to verify your identity. See fdic.gov/deposit/deposits/prepaid.html for details.

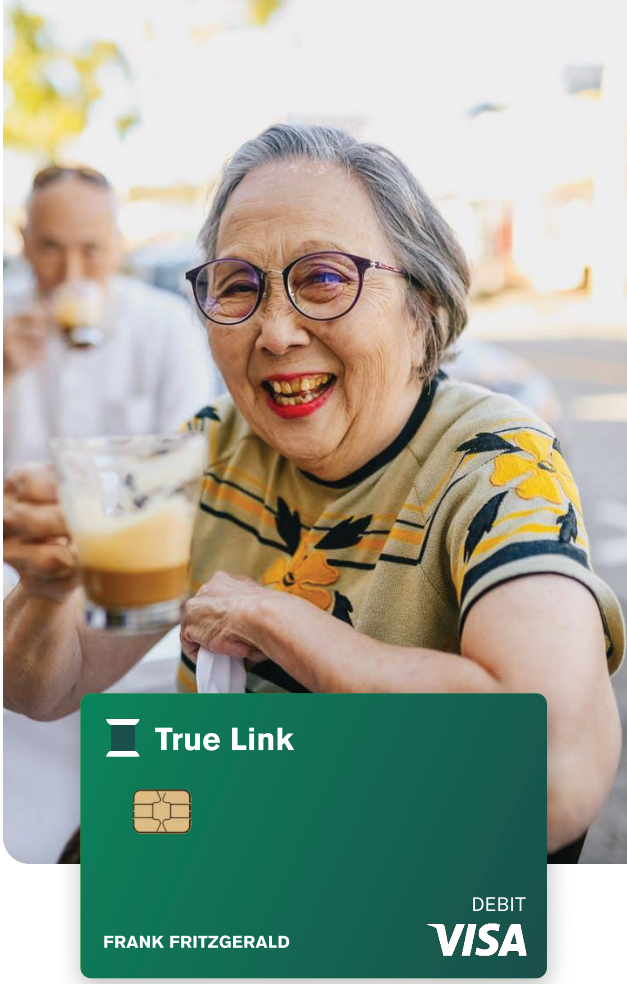
No overdraft/credit feature.

Contact us by calling 1-800-299-7646 by mail at True Link Financial, Inc., PO Box 581, San Francisco, CA 94104 or visit www.truelinkcard.com.

For general information about prepaid accounts, visit cfpb.gov/prepaid.
If you have a complaint about a prepaid account, call the Consumer Financial Protection Bureau at 1-855-411-2372 or visit cfpb.gov/complaint.

True Link

Congratulations on receiving your True Link Independence Visa® Prepaid Card*!



True Link Independence Visa Prepaid Card

Note: There is not an option for cash back with this card.

Your True Link Card is a Visa Prepaid Card that has been set up for you by your payee. Your Visa card can be used to make purchases everywhere Visa debit cards are accepted. Additional benefits of your Visa card include:

- No more waiting for checks to arrive in the mail
- No more trips to the bank or check-cashing services that charge expensive check-cashing fees

Making purchases in a store and setting a PIN on your Visa card
Your Visa card works by swiping the magnetic strip. A merchant may ask you for a PIN when completing your purchase. If you do not have a PIN or cannot remember your PIN, select "Credit" on the payment terminal or let the merchant know that you want to run the card as "Credit" so they can assist you. Setting a 4-digit PIN on your Visa card is necessary if you are going to make debit purchases. To set a PIN on your card, dial 1-800-299-7646, listen for the "reset your PIN" option, press "4", and follow the instructions.

What to do if your Visa card is lost or stolen
If your Visa card has been lost or stolen, it is important to let us know as soon as possible. You may do this by calling 1-800-299-7646. When the automated phone system lists the option report a card as lost or stolen, press 5. This will let True Link and your rep payee know that your Visa card has been lost or stolen and also protect the funds on your current Visa card. Your rep payee will then work with True Link to order a replacement card for you.

We offer four ways for Cardholders to check the balance of their card, all of which are available anytime.

MOBILE APP: For Cardholders with either an iPhone or Android device, they will be able to download our mobile app! Our mobile app can provide you with the available balance of your card, your recent transaction history, and when your next scheduled transfer will become available.

PHONE CALL: You can check your balance anytime using True Link's phone system. Simply call 1-800-299-7646. You can also use this system to review recent transactions or hear when you can expect more funds on your Visa card.

TEXT MESSAGE: As long as True Link has your mobile number on file, you can check your balance by sending a text message from your phone. Text the word BALANCE to the number on the back of your Visa card, 1-800-299-7646. (Standard text message rates, fees, and charges may apply.)

ONLINE: You can view your Visa card balance, recent transactions, spending rules, and more at www.truelinkfinancial.com.

1. Visit www.truelinkfinancial.com
2. Click "LOG IN" at the top right part of the page.
3. Under the "I use a True Link Card" heading, enter the last four digits of your Visa card number and click "Continue."
4. Enter the last four digits of your Social Security number and your date of birth, and you'll be logged in!

*This card is issued by Sunrise Banks N.A., St. Paul, MN 55103, Member FDIC, pursuant to a license from Visa U.S.A. Inc. This card can be used everywhere Visa debit cards are accepted. Use of this card constitutes acceptance of the terms and conditions stated in the Cardholder Agreement.

** If you call us we may ask you for your birthdate and/or social security number for verification or card activation purposes.

Making purchases in a store and setting a PIN on your Visa card

Your Visa card works by swiping the magnetic strip. A merchant may ask you for a PIN when completing your purchase. If you do not have a PIN or cannot remember your PIN, select “Credit” on the payment terminal or let the merchant know that you want to run the card as “Credit” so they can assist you. Setting a 4-digit PIN on your Visa card is necessary if you are going to make debit purchases. To set a PIN on your card, dial 1-800-299-7646, listen for the “reset your PIN” option, press “4”, and follow the instructions.

Using True Link’s phone system to manage your Visa card

In addition to checking your card balance and setting a PIN, you may use True Link’s automated phone system to hear additional information about your Visa card, such as a list of any upcoming transfers that have been scheduled or a list of recent transactions.

What to do if your Visa card is lost or stolen

If your Visa card has been lost or stolen, it is important to let us know as soon as possible. You may do this by calling 1-800-299-7646. When the automated phone system lists the option report a card as lost or stolen, press 5. This will let True Link and your rep payee know that your Visa card has been lost or stolen and also protect the funds on your current Visa card. Your rep payee will then work with True Link to order a replacement card for you.

Questions about your card?

If you have questions about the way your Visa card has been set up for you or if you have been declined when trying to make a purchase and aren’t sure why, please contact your rep payee. They will be able to review your True Link system card settings with you and address any concerns.

You can also call True Link’s Customer Support team at 1-800-299-7646 and request to speak to a representative. Live representatives are available by phone **Monday through Friday, between 7 am and 5 pm Pacific Time**. True Link also responds to voicemails left at **1-800-299-7646** and emails sent to **support@truelinkfinancial.com** 365 days a year.

children & families of iowa

Protective Payee Services

DEBIT CARD CONSENT FORM

Date: _____

First Name: _____

Last Name: _____

Date of Birth (MM/DD/YY):____/____/____

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 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. This consent is binding through the entirety of services through CFI.

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 canceled.

X _____ X _____

Client Signature Date

X _____ X _____

Guardian/Legal Representative PRINT NAME Date

X _____ X _____

Guardian/Legal Representative Signature Date

X _____ X _____

PPS Manager PRINT NAME (CFI) Date

X _____ X _____

PPS Manager Signature Date

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Protective Payee Services

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

Identifying info **all questions must be answered**, or application cannot be competed with Social Security.

Client Name: _____ Social Security # _____
DOB: _____ Place of Birth: _____ Mother's Maiden Name _____

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

Plans to Move Within 6 months: Yes❑ No❑ Date: _____ Address: _____

Current Cell Phone #: _____ House Phone #: _____

Does Client currently have a Payee? Yes❑ No❑ If yes, who is Current Payee? _____
Reason for needing a payee or reason for change of 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: _____
Have you included proof of guardianship Yes❑ No❑ NA❑

LIVING ARRANGEMENT

❑Alone ❑With Roommates _____# of Roommates ❑Spouse/Significant Other ❑With Relative
❑Residential Facility/Provider?_____ ❑Host Home/Service Provider? _____
❑Group Home/Service Provider? _____ ❑Other _____

Emergency Contact Name: _____ Phone: _____
Address: _____ City/State/Zip: _____
E-mail _____

Case Manager/Name: _____ Agency: _____
Phone# _____ Email: _____ Title: _____
Provider/Name: _____ Agency: _____
Phone# _____ Email: _____ Title: _____
Housing Staff/Name: _____ Agency: _____
Phone# _____ Email: _____ Title: _____

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Protective Payee Services

Social Security Review & Client Registration Form

CLIENT DEMOGRAPHIC INFORMATION

Gender: ❑Male ❑Female ❑Other

Race (Check 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

Primary Language Spoken: _____ English Proficient? Yes❑ No❑

INCOME

SSI Income: $_____ **SSDI Income:** $_____ **Wages Only:** $_____

Does prospective client receive Snap Benefits: Yes❑ No❑ Amt: $_____

EMPLOYMENT

❑Employed ❑Unemployed ❑Retired ❑Student ❑Part Time ❑Minor

Current Employer: _____

Please note pay stubs must be reported to social security.

Will you be turning in pay stubs to us? Yes❑ No❑

❑Fax them to Social Security

❑Use the Social Security app

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

❑ Hospitalized, Location _____

❑ In Jail

❑ None of the Above

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: ☒ 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 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

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. This consent is binding through the entirety of services through CFI or when services through the above named organization or individual changes.

X _____ X _____

Client Signature Date

X _____ / _____ X _____

Guardian or Legal Representative Signature Relationship to Client Date

X _____ X _____

Witness Signature (CFI) Date

X _____ X _____

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

Prohibition of Re-disclosure: 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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Protective Payee Services

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.

Children & Families of Iowa's Protective Payee Services Program is a for fee Payee service. The fee for our services is set by the Social Security Administration and are subject to change annually. Payee fees will be charged to the account as "Client fees" and paid to Children & Families of Iowa.

In 2025 the fee amount was set at $55.00. This fee will increase yearly with the cost-of-living increase for clients and is typically an increase of $2 each year. Children & Families of Iowa will notify the client by posting the increased rate change in our office once notified by Social Security.

X _____ X _____

Client Signature Date

_____ X _____

Guardian/Legal Representative PRINT NAME Date

X _____ X _____

Guardian/Legal Representative Signature Date

X _____ X _____

Witness Signature (CFI) Date

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Protective Payee Services

INTAKE CHECKLIST AND CONSENT TO PARTICIPATE

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 _____

Client Signature Date

X _____ X _____

Guardian/Legal Representative Signature Date

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 _____

Client Signature Date

X _____ X _____

Guardian/Legal Representative Signature Date

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 _____

Client Signature Date

X _____ X _____

Guardian/Legal Representative Signature Date

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 Signature Date

X _____ X _____

Guardian/Legal Representative Signature Date

X _____ X _____

Witness Signature (CFI) Date

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Protective Payee Services

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 _____ X _____

Client Signature Date

X _____ X _____

Guardian/Legal Representative Signature Date

X _____ X _____

Witness Signature (CFI) Date

X _____ X _____

Case Manager Date

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Protective Payee Services

THINGS TO NOTE ONCE YOU ARE A CLIENT

Hours of Service: 9:00AM – 3:00PM, Monday-Friday, except Major Holidays

- **IF PAYDAY IS ON A WEEKEND OR HOLIDAY, SOCIAL SECURITY DEPOSITS WILL ALWAYS ARRIVE THE FRIDAY BEFORE**

What does this mean for the client?

- **Via paper check on payday- when paydays fall on a weekend or holiday, the client can pick up paper checks the Friday before.**
- **Via debit card on payday- The card will load the day after the holiday/payday.**

- **1 EXTRA CHECK A MONTH up to $100** can be requested on an EXTRA CHECK REQUEST FORM, or a call request **IF the client has the extra funds available in their account.**

**Purchases beyond $100 require a suspended receipt. There are two ways to do a suspended receipt.

1. In store: go shopping for the items you wish to purchase, take them up to the register and have them rang up. Ask for a suspended/training receipt that shows all the items with the total after taxes. Bring the receipt to your payee, who will cut you a check to go back and pick up your items. If you have a debit card, you can email a picture of the suspended receipt, and your payee can load the funds to your debit card immediately.
2. Online: Put the items you want to purchase in your "cart". Email screenshot of the items in your cart with the total **after** taxes. Your payee can then load the funds to your debit card or cut you a check if you don't have the debit card.

CFI Protective Payee Services can receive mail addressed to Clients, such as Paperwork, Medical Cards, FIP, Annual Insurance Booklets, Notifications, Updates, etc. The client will be notified and **can pick up any mail addressed when in the office.**

*PLEASE NOTE:

ANY DOCUMENTS/FORMS THAT NEED FILLED OUT IS THE RESPONSIBILITY OF THE CLIENT/ STAFF/ PROVIDER/GUARDIAN.

CFI DOES NOT FILL OUT MEDICAID REVIEWS, FOOD STAMP REVIEWS, HOUSING ASSISTANCE RENEWALS, RENT REIMBURSEMENT, OR ANY OTHER FORM OF ENTITLEMENT PAPERWORK.
******CFI will provide all financial information required to complete these reviews.**

CFI DOES NOT APPLY FOR PROGRAMS FOR CLIENTS SUCH AS FOOD STAMPS OR HOUSING ASSISTANCE.

CFI DOES NOT COMPLETE AND FILE INCOME TAX RETURNS.

CFI DOES NOT OPEN OR MANAGE IABLE ACCOUNTS—IF AN IABLE IS ESTABLISHED, FUNDS WILL BE TRANSFERRED ELECTRONICALLY UPON GIVEN THE LOG IN INFO TO THE IABLE ACCOUNT.

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.***