

Family Partnerships of Central Florida

PROCEDURE

Series:	Operating Procedures	COA: FIN 7.09 CFOP: 175-59
Procedure Name:	Master Trust for Benefit of FPoCF Program Clients	
Procedure Number:	OP-1059	
Reviewed Date:	5/14/2018, 3/6/2020, 04/16/24	
Revision #/Date:	7/30/21	
Effective Date:	06/26/17	
Applicable to:	All Family Partnerships of Central Florida Staff and Contract Providers	

PURPOSE: To ensure that Family Partnerships of Central Florida assist clients in accessing funds from their master trust accounts for eligible expenses and cost of care and to ensure fiduciary responsibility as representative payee for client's money and property.

PROCEDURE:

References

Florida Laws Chapter 96-402
F.S. 402.33

Establishing a Master Trust Account

- a. Upon placement and notification of a child in licensed out of home care, FPoCF Rev Max screens the case for third party benefits from Social Security. Cases are screened for potentially eligible clients that may be disabled or whose parents are deceased. Clients who do not have an open record with Social Security may still be eligible to receive benefits. Family Partnerships of Central Florida Care Managers (CM) are also required to assess the clients' history to determine potential eligibility. If such eligibility is determined, the FPoCF Accountant or other designee will complete the Notarized Designation of Client Money and Property.
- b. Upon receipt of the Notarized Designation of Client Money and Property, FPoCF Finance will:
 - (1) Establish the subaccount(s) as indicated on the form.
 - (2) Notate on the form that the subaccount(s) has (have) been established, sign and date the form.
 - (3) Maintain the original form in the child's fiscal file; and,
 - (4) Notify Rev Max that the subaccount(s) for the child has been established. Rev Max will, in turn, notify the Family Partnerships of Central Florida CM that the account has been established.

Family Partnerships of Central Florida

- (5) The Family Partnerships of Central Florida CM is responsible for notifying child welfare legal staff that an account has been established and providing legal with any information they may need in establishing and maintaining the child's trust fund.
- (6) The Care Manager is required to apply for social security for children in licensed care upon a parent death or new diagnosis that meets qualifications. The application can be found at SSA.gov. If the child is placed in a relative or fictive kin placement the caregiver should apply. It should be noted that it is not unusual to be denied, and if denied the appeal process should be pursued.
- c. The child welfare legal services office will notify the juvenile court of the establishment of a Master Trust account for the child. This may be accomplished by filing a copy of the Notarized Designation of Client Money and Property with the court.

NOTE: When a child enters care and is not receiving benefit payments, if the circumstances so warrant, the Family Partnerships of Central Florida CM will work with Rev Max to apply for benefits. Such circumstances include a deceased parent or the child having a qualifying condition such as being blind or disabled.

Managing Client Trust Fund Accounts

The Social Security Administration sends the clients monthly SSI or SSA payments to FPoCF. The FPoCF Finance Department is responsible for the accounting of each client's trust fund. When withdrawal requests are received, a check is cut. All checks are sent directly to the Family Partnerships of Central Florida Care Manager unless specified otherwise in special instructions. The Care Manager is responsible for delivering the check to the named vendor where the item(s) is being purchased, as well as ensuring that the original receipts are submitted to the fiscal department within 10 days of receipt of disbursement.

- a. SSI accounts have a \$2,000 asset limit. This means that if their account exceeds \$2,000 at any time, the Social Security Administration can suspend their benefits, including Medicaid. When a trust account reaches \$1,200, an expenditure plan must be created and implemented by the Family Partnerships of Central Florida CM. A copy of this plan is to be kept in the child's file.
- b. SSA accounts do not have an asset limit but must remain below \$20,000 to ensure no offset for income level in determining Medicaid.
- c. Clients who receive dual payments, both SSI and SSA are also limited to \$2,000, before benefits could be suspended.
- d. The client's monthly cost of care (room & board payment) is deducted from the client's monthly SSA/SSI payments. For example, if a client received \$500 from Social Security and their monthly cost of care is \$450, then the client will have \$50 added to their trust fund balance. Exceptions may be granted through the fee waiver process.
- e. A minimum of \$40 must be added to each account that receives a monthly Social Security payment. For example, if the client received \$500 from Social Security and their monthly cost of

Family Partnerships of Central Florida

care is \$600, then they will have \$40 added to their trust fund balance and \$460 deducted to cover their cost of care.

f. The Family Partnerships of Central Florida CM must perform planning and budgeting functions by keeping track of the client's Master Trust Fund balance(s), monitoring the client's current and anticipated needs in relation to such balance(s) and the best interests of the child, and communicating such needs to FPoCF.

g. To assist the Care Manager in planning and budgeting, FPoCF sends the master trust balance and transaction report to the CM, Center Care Program Director, and Child Welfare Director monthly.

h. The Family Partnerships of Central Florida CM is responsible for keeping the client, court, and family informed of the status of the client's account. The judicial review social study report must include Master Trust accounting information.

i.. The 285 B is initially completed when the child starts to receive SSI/SSA benefits to let the child know that they are receiving benefits and that the cost of care may be applied.

Managing Client Trust Fund Purchases

- a. Funds in the Client's Master Trust account can be used for purchasing items related to the child's ongoing needs. This may include clothing, personal items, sports activities, computers, recreational activities, allowance (not replacing an allowance from the foster parent), music or art lessons, therapies not covered by Medicaid, tutoring, etc.

Purchasing plans are completed with the caregiver and the client and if the child is old enough to understand they should have input into the plan. As the child approaches 18 the CM works with CLS to ensure a motion is filed related to the disbursement of the Master Trust funds.

The Master Trust Check Disbursement Request form must be completed and provided to FPoCF finance with a copy placed in the clients hard file for all requests.

- b. If the purchase cost for the client exceeds \$500, approval from the client's Guardian ad Litem is needed and must be attached to the Disbursement Request.

The Settlement for Allowance form must be completed and returned to FPoCF finance after payment is issued.

Managing Client Trust Fund Purchases

The request for waivers from Master Trust Fund being used as Maintenance Fees can be made at any time if a child has a specific need and is usually for a limited duration or for a limited sum. Reasons for the waiver may include, but are not limited to;

- a. the need for security and utility deposit when a child is transitioning to IL.
- b. specialized classes if the child has special talent or interested such as sports, music, arts, visual aids

Family Partnerships of Central Florida

- c. wheelchair for mobility-limited child or sensory toys for autistic child
- d. remedial tutoring
- e. items for the child's IL or PASS Plan
- f. prepaid college tuition program
- g. or childcare if youth is a parent.

To apply for a fee waiver the following must be completed and provided to the FPoCF finance team. Who will then provide the information to DCF for a decision to be made.

- a. Notice of Fee Assessment and Rights of Foster Child (attached)
- b. Application for Review of Assessed Fee (attached)
- c. Certification and Affidavit of Understanding (attached)
- d. The Fee Waiver Budget Worksheet
- e. The youth's case plan or Independent Living plan needs to be included, to show this purchase is in line with her goals/plans.
- f. Supporting verification of the cost of the specific need identified. These can be in the form of receipts, estimates, printouts of sample prices, etc.
- g. A copy of the most recent Notice of Maintenance Fee to be Charged (form 285D), this gets filed with the youth's JR.

The Care Manager is required to provide notice to the child about their rights to request a fee waiver at every JR, in accordance with 65C-17.005 F.A.C.

BY DIRECTION OF THE PRESIDENT AND
CHIEF EXECUTIVE OFFICER:



PHILIP J. SCARPELLI
President and Chief Executive Officer
Family Partnerships of Central Florida

APPROVAL DATE: 04/17/2024

APPLICATION FOR REVIEW OF ASSESSED FEE OR CHANGE IN ALLOWANCE

PART A: To be filled out by client or other person requesting review on behalf of the client.

Date of application: _____

Program: Family Safety Foster Care

Client: _____

Person requesting review (if different than client): _____

Address and phone number of requester (if different than client):

Street: _____

Apt: _____

City: _____

Zip: _____

Phone: (____) _____ - _____

Account number (if known): _____

Date entered foster care: _____

Type of Request:

- ☐ Request for monthly re-assessment to \$ _____. Period of time: _____.
- ☐ Request for "one time" credit of \$_____.
- ☐ Request for change in allowance from \$ _____ per month to \$_____ per month.

Reason for request (attached relevant documentation, including copy of PASS, PASS-ND, Independent Living or other case plan; requester must sign attached Certification and Affidavit of Understanding which verifies that the requester has not misrepresented facts; that requester, on behalf of the client, will spend any amount provided by the department as fee waiver, or ensure that such amount approved as an increased allowance is spent on the goods or services requested; that the requester understands that any fee waiver or change in personal allowance is subject to availability of funding; and that information obtained by requester during this proceeding is subject to confidentiality laws).

_____.



CERTIFICATION AND AFFIDAVIT OF UNDERSTANDING

I, _____, hereby certify that the information which I have provided in applying for a fee waiver or a change in the foster care or personal allowance on behalf of _____, is accurate and true to the best of my knowledge. I also certify that the money which is being requested as a fee waiver or a change in the foster care or personal allowance will be spent on the goods and services listed in the "reason for request on page 1 of the application. Finally, when this application is a request for fee waiver, and not for a change in the foster care or personal allowance, I certify that I will provide receipts to the Chair of the Fee Review Committee for the purchase of the goods or services listed within 30 days of receiving the total sum of the approved fee waiver amount or be liable for repayment of the full amount to the department. I understand that any fee waiver or a change in the foster care or personal allowance is subject to availability of funding.

I, _____, further understand that I am required by applicable state and federal laws and regulations to hold this information confidential and cannot release any confidential information to any person or entity not entitled by law to receive it. I understand that I may be guilty of a misdemeanor of the second degree and liable to civil suit if I violate that confidentiality.

Date: _____

Signature

Witness



Family Partnerships of Central Florida

SETTLEMENT FOR ALLOWANCE

Client's Name: _____

Check No.: _____

Please have client sign this form by: _____ and return to the Family Partnerships of Central Florida office at 389 Commerce Parkway, Suite 120, Rockledge, FL 32955.

NO OTHER CHECKS FOR THIS CLIENT WILL BE ISSUED UNTIL SETTLEMENT OF THIS CHECK IS RECEIVED.

I, _____, received on _____,
(name) (date)

A check for my allowance in the amount of \$_____.

Family Partnerships of Central Florida

Client's Name: _____

Check No.: _____

Please have client sign this form by: _____ and return to the Family Partnerships of Central Florida office at 389 Commerce Parkway, Suite 120, Rockledge, FL 32955.

NO OTHER CHECKS FOR THIS CLIENT WILL BE ISSUED UNTIL SETTLEMENT OF THIS CHECK IS RECEIVED.

I, _____, received on _____,
(name) (date)

A check for my allowance in the amount of \$_____.

Family Partnerships of Central Florida

Account Type: Circle one: Current Needs Account or Dedicated Lump Sum Account

Payee Name:

Amount Requested:

Payee Street Address:

City: State: Zip: _____

GAL approval attached for requests of \$500 or more: Circle one: YES, or N/A

Items to be purchased:

Purpose/Justification:

I am requesting the above purchase(s) to be made from my trust account. I understand that this request must be approved, and any changes must be approved. I also understand that the original receipt, or receipts and cash, totaling the amount of the check must be returned.

Client's Signature

Date

Justification if client cannot sign: _____

Client Name:

Client DOB:

Client SSN:

CARE MANAGER SIGNATURE

I certify that the goods/services requested are for the current needs of the client referenced above. Additionally, I understand that any changes to this request are permitted only with the written approval of all authorized officials. Furthermore, it is understood that original receipts, or receipts and cash, totaling the check amount must be returned to the FPoCF Finance Office within 10 days of the check date.

Care Manager's Signature	Printed Name	Telephone	Email Address	Date

SIGNATURES BELOW INDICATE APPROVAL OF THE REQUEST

Care Manager Supervisor Signature	Printed Name	Telephone	Email Address	Date

Care Center Manager Signature	Printed Name	Telephone	Email Address	Date

Clinical Services Coordinator	Printed Name	Telephone	Email Address	Date

PAYMENT AUTHORIZATION BY FPoCF FINANCE

Chief Finance Officer Signature	Printed Name	Date

Signature of Preparer	Printed Name	Date	Check Number

CHECK PICKUP INFORMATION

Signature: _____ Date: _____ Printed Name: _____



FROM: _____ Title: _____ Phone: _____

RE: Child's Name: DOB:

☐ Is holding moneys for the child in trust. The source of these funds is

Page 9 of 12

Family Partnerships of Central Florida

hearings are confidential and shall not be disclosed to unauthorized third persons pursuant to state and federal laws and regulations.

The Department is obligated to manage the Social Security, federal benefit, or other payment or asset in trust for the child and has a duty to protect both the child's short-term and long-term financial interests. The Department must balance the special needs of the child against the fee assessment for the cost of the child's care, in the child's best interest.

In the case of a child aged 15 or older, the Department must also take into account the child's need to be able to function as an adult at age 18 and must balance this need in the child's best interest against the fee assessment for the cost of the child's care.

For any child who receives Supplemental Security Income (SSI), the child's receipt of a monthly benefit is subject to a \$2,000 asset maximum.

To apply for a fee waiver for the child, you must do one of the following:

1. Complete and mail the attached "Application for Review of Assessed Fee;" or,
2. Send a letter to

___ and include information as to why the fee should be waived.

In your application or letter, please include any information and supporting documentation within your own knowledge regarding any special needs of the child that are currently unmet. In addition, for a child 15 or older, please describe the child's need to prepare for independent living or for adulthood. If the child receives SSI benefits, please also include an individualized plan for ensuring he or she will accumulate less than \$2,000 in countable assets.

As trustee of the child's money and property, the Department or CBC is required to provide an annual accounting update of how the Department or CBC used the child's benefit payments on the child's behalf and the amount being held in trust for the child. To request the most recent accounting statement, please contact:

FLORIDA DEPARTMENT OF
CHILDREN AND FAMILIES
MYFLFAMILIES.COM

To be filled out by child or other person requesting review on behalf of the child.

Page 11 of 12

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Requester's Signature _____

Date Signed _____