| State of Kansas  Department for Children and Families  Prevention and Protection Services | **WARDS ACCOUNT**  **Close-Out**  **Worksheet** | PPS 5927B  October 2019 |
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| When DCF is no longer the Representative Payee of a foster child’s benefit, the worker shall review expenses to ensure DCF has been reimbursed for cost of care to the extent that it can. Before closing out a case, all deposits must be approved or disapproved. Follow these steps to see if any cost of care can still be reimbursed. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| WARDS Worker’s Name: | | | | | | |  | | | | | | | | Date Worksheet Completed: | | | | | | | | | | | | | | | |  | | |
| WARDS Client’s Name: | | | | | | |  | | | | | | | | | | Client ID#: | | | | | | | |  | | | | | | | | |
| Client SSN: | | | | | | | last 4 digits | | | | | |  | | |  | | | Client DOB: | | | | |  | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| STEP 1 | Dates DCF was Payee: | | | | | | | | |  | | | | | | | | to | | |  | | | | | | | | | | |  | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| STEP 2 | | | Were any approved expenses NOT paid in full to DCF? | | | | | | | | | | | | | | | | | | | Yes | | | | | | | | No | | | |
|  | | |  | | |  | | |  | |  | | |  | | | | | |  | | | | | |  | |  | **Skip to End** | | | | |
|  | | | If yes, attach the Expense Detail report and list the expenses (service ID#s/amount not reimbursed) here: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| STEP 3 | | | Is there still a balance in the client’s account after applying expenses from STEP 2? | | | | | | | | | | | | | | | | | | | Yes | | | | | | | | No  **Skip to End** | | | |
|  | | | | If yes, complete PPS 5927A and attach all to this form. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | |  | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | |
| STEP 4 | | | | Request a manual expense by completing this section and sending the completed form, with attachments, to the WARDS Accountant. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **To WARDS Accountant:** | | | | | | | | Please do a manual expense from this client’s WARDS account. (see client info above.) If PPS 5927A also attached, complete any request with it, and then return the balance in the client’s account to Social Security. | | | | | | | | | | | | | | | | | | | | | | | | | |
| Payee: | | | | | | | | | | | | | | | | | |  | | | | |  | | | | | | | | | | |
| Total Amount: | | | | | $ | | | |  | | | | | | | | |  | | | | |  | | | | | | | | | | |
| Reason: Reimbursement for cost of care (date/ServiceID/amount not reimbursed – list as many that apply): | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| For WARDS Accountant Use: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Request Recv’d: | | | | |  | | | | Check #: | | |  | | | | | | Date on Check: | | | | | | | | |  | | | | | | |

[](http://srsshare.srs.ks.gov/communications/Graph/Official%20Logos/DCF%20Logos/DCF-black.png)