State of Kansas
Department for Children and Families
Prevention and Protection Services

DCF GSO Reporting Form

PPS 5928
Aug 2012

Attn:

DCF eData Reporting Form

Date of Report: ____________ Reporter's Name: ____________

Claimant's Name: ____________ Position: ____________

Social Security Number: ____________ Location: ____________

Parent's SSA Claim Number: ____________ Phone Number: ____________

FAX Number:

☐ **Payee Change:**

to: Choose One Date of Change:

Name of New Payee: ____________ Payee's Phone: ____________

Address of New Payee: ____________ Best Time to Call: ____________

Reason for Change:

☐ **Placement Change:** Date of Change: ____________

Old Placement Name: ____________ Old Type: Choose One

Old Address: ____________

New Placement Name: ____________ New Type: Choose One

New Address: ____________

Cost of Care: ____________ Unit: Choose One

SSI Funding Source: Choose One

☐ **Income Change:** Date of Change: ____________

Type: Choose One Choose One

Monthly Amnt: _____ Choose One

☐ **Resource Change:** Date of Change: ____________

Reason: Choose One

☐ **School Change:** Attending? Choose One Effective Date:

Name & Address of School: ____________

Comment: ____________

DCF: For clients 17-1/2 complete and mail back the Student Report when received.

☐ **Other Changes:** Type: Choose One

Date of Change: _____

☐ **Multi-Month Distribution Request:** Date of Deposit: ____________ Amount: ____________

Requested Dates: From: ____________ To: ____________

Expenses Incurred: (see attached) DCF: Ask for an expense report from SCRIPTS

Average Monthly cost of care: ____________

Is client nearing age 18? ☐ Yes ☐ No If yes, has the need to conserve these funds for IL been considered? ☐ Yes ☐ No

☐ **Additional Comments:**