MEMORANDUM OF AGREEMENT TO ESTABLISH PROTECTIVE PAYMENTS

DEPARTMENT OF HEALTH AND HUMAN SERVICES
ECONOMIC ASSISTANCE
SFN 429 (9-2024)

Clear Fields

I. Agreement

Name of Recipient			
Address	City	State	ZIP Code

I Agree:

1. To administer the recipient's public assistance funds consistent with the best interests of the child(ren) listed in Section II, according to a plan approved by the Human Service Zone Office;
2. To hold in strict confidence any information about the family which becomes known to me in my role as protective payee; and
3. To make a reasonable accounting of the assistance funds I spend in behalf of the family, as may be required.

Signature of Protective Payee	Date

II. Child(ren) for Whom Protective Payments are to be Made

NAME	AGE

III. Information About Protective Payee

Name			
Address	City	State	ZIP Code
Telephone Number	Relationship		

IV. Designation

Appointed Protective Payee	Appointment Date
Signature of Authorized Person	Date
Title	

DISTRIBUTION: Original - Protective Payee
Copy - Recipient
Copy - HSZ Eligibility File