Adoption Assistance Application

The prospective adoptive parent(s), custodial agency, or tribe completes this form on behalf of the child and submits it to the Children and Family Services Division (CFSD), Post Adoption Services Unit.

1. Case status

☐ Pre-finalization status – The prospective adoptive parent receives no monetary payment.

☐ Finalization date set - The prospective adoptive parent receives a foster care maintenance payment, the child's Supplemental Security Income (SSI), or other source of income on child's behalf. Finalization date:

☐ Post-finalization status – The adoption is finalized. – *For CFSD Post Adoption Section use only*

2. Identifying information

Adoptive family

Father	Social Security number	Date of birth
Race or ethnicity	Home telephone	Work telephone
E-mail address		Cell phone

Mother	Social Security number	Date of birth
Race or ethnicity	Home telephone	Work telephone
E-mail address		Cell phone

Address	City	State	Zip Code

Adoption specialist	County
Tribal Child Welfare (CW) worker	Tribe

Adoptive child 1

Birth name or other legal name		Adoptive name	
Date of birth	Gender ☐ Male ☐ Female	Race or ethnicity	Tribe
Social Security number	Adoption authorization date		Adoptive placement date
Birth KK number	Adoption KK number	Medical identification	Other case number(s)

Adoptive child 2

Birth name or other legal name		Adoptive name	
Date of birth	Gender ☐ Male ☐ Female	Race or ethnicity	Tribe
Social Security number	Adoption authorization date		Adoptive placement date
Birth KK number	Adoption KK number	Medical identification	Other case number(s)

Adoptive child 3

Birth name or other legal name		Adoptive name	
Date of birth	Gender ☐ Male ☐ Female	Race or ethnicity	Tribe
Social Security number	Adoption authorization date		Adoptive placement date
Birth KK number	Adoption KK number	Medical identification	Other case number(s)

Adoptive child 4

Birth name or other legal name		Adoptive name	
Date of birth	Gender ☐ Male ☐ Female	Race or ethnicity	Tribe
Social Security number	Adoption authorization date		Adoptive placement date
Birth KK number	Adoption KK number	Medical identification	Other case number(s)

3. General information

Foster parent adoption? Yes ☐ No ☐

Relative adoption/non-related kinship adoption? Yes ☐ No ☐

Receiving foster care payments? Yes ☐ No ☐

Adoptive family receives Temporary Assistance for Needy Families (TANF)?

☐ Yes ☐ No If yes, amount: $ _____

Adoptive family receives Supplemental Security Income (SSI) on the child's behalf?

☐ Yes ☐ No If yes, amount: $ _____

Adoptive family receives other income on the child's behalf?

☐ Yes ☐ No If yes, type of income: _____ / amount: $ _____

This space intentionally left blank.

4. Special needs determination

When the answer to questions one, two, and three is yes, the child is determined to have special needs. Complete a section 4 for each child. Make additional copies of this section as necessary.

Child's name: _____

1. Yes ☐ No ☐ **The child cannot return home.**

If yes, attach:

- motion for termination of parental rights (TPR);
- TPR order;
- relinquishment of parental rights document;
- verification of death of parent; or
- KIDS TPR screenprint.

**If state or tribal law allows a child to be adopted without a TPR or relinquishment, only a statement addressing why the child must not return home is required.*

2. Yes ☐ No ☐ **Special factors or conditions exist.**

The child meets at least one of the factors or conditions listed.

Check each applicable condition and write a brief statement supporting the assessment of the need.

☐ Physical disability — The child requires regular treatment and has a specific diagnosis.

**Attach a current statement signed by a licensed physician, psychiatrist, or clinical psychologist describing the condition, including diagnosis, treatment, and prognosis.*

Statement supporting assessment of physical disability:

☐ Mental disability — The child is educable multi-handicapped (EMH), trainable multi-handicapped (TMH), or has a demonstrable need for intensive adult supervision beyond ordinary age needs.

**Attach a current statement signed by a licensed physician, psychiatrist, or clinical psychologist describing the condition, including diagnosis, treatment, and prognosis.*

Statement supporting assessment of mental disability:

☐ Age — The child is placed with a kinship non-related person or a relative who provides paid or non-paid kinship care who meets the specified degree of relationship as defined in OAC 340:10-9-1, making the age requirement inapplicable.

☐ Age — The non-minority child is eight years of age or older and placed with a non-relative.

Statement supporting assessment of child's age:

☐ Sibling relationship — The child is part of a sibling group as specified in OAC 340:75-15-128.4.

Statement supporting assessment of child's sibling relationship:

☐ Emotional disturbance — The child's emotional disturbance is established by a physician, psychologist, behavioral therapist, or social worker *and* corroborated by the Child Welfare worker's observations and one or more caregivers *and* documented with a specific diagnosis and prognosis, when applicable.

**Attach a current statement signed by a licensed physician, psychiatrist, or clinical psychologist describing the condition, including diagnosis, treatment, and prognosis.*

Statement supporting assessment of child's emotional disturbance:

☐ Racial or ethnic factor	The child is American Indian, Hispanic or Latino, Asian, or African American, *and* three years of age or older.

Statement supporting assessment of child's racial or ethnic factor:

☐ High risk of physical or mental disease	The child displays indicators of high risk physical or mental disease for conditions that are not currently treated. Indicators of high risk for physical or mental disease include social and medical history, such as mental illness of a biological parent or family member, events or life experiences such as severe sexual abuse and prenatal exposure to drugs or alcohol. **When no other special needs criteria are present, no monthly payment is made until there are documented symptoms of physical or mental disease.*

Statement supporting assessment of child's high risk of physical or mental disease:

3. ☐ Yes ☐ No

Efforts to place the child without assistance are unsuccessful.

A reasonable but unsuccessful effort was made to place the child without assistance, except where it is against the child's best interests due to factors such as a strong emotional tie to a foster parent who plans to adopt the child or placement with a relative.

**Foster and relative adoptions meet this criterion.*

Document efforts to place the child without assistance. Include specific recruitment efforts to locate an adoptive parent who can meet the child's special needs.

Area staffings:

Adoption parties:

Adoption resource exchanges:

Media and Internet efforts:

Other efforts:

This space intentionally left blank.

6. Requested benefits

☐ I am ***not*** requesting adoption assistance benefits at this time, but may in the future if needed for child:

What future needs may the child have?

☐ I am ***not*** requesting adoption assistance benefits at this time, but may in the future if needed for child:

What future needs may the child have?

☐ I am ***not*** requesting adoption assistance benefits at this time, but may in the future if needed for child:

What future needs may the child have?

☐ I am ***not*** requesting adoption assistance benefits at this time, but may in the future if needed for child:

What future needs may the child have?

Child's name	**Benefits requested**	**Monthly amount requested**
Adoptive name: _____	☐ Medicaid ☐ Monthly payment ☐ Special services ☐ Employment-related child care ☐ Non-recurring adoption expenses – *Not to exceed current amounts allowed per OKDHS rules.* ☐ Other: _____	$

Explain how OKDHS and the adoptive family agreed upon the requested monthly amount:

Child's name	**Benefits requested**	**Monthly amount requested**
Adoptive name:	☐ Medicaid ☐ Monthly payment ☐ Special services ☐ Employment-related child care ☐ Non-recurring adoption expenses – *Not to exceed current amounts allowed per OKDHS rules.* ☐ Other:	$

Explain how OKDHS and the adoptive family agreed upon the requested monthly amount:

Child's name	**Benefits requested**	**Monthly amount requested**
Adoptive name:	☐ Medicaid ☐ Monthly payment ☐ Special services ☐ Employment-related child care ☐ Non-recurring adoption expenses – *Not to exceed current amounts allowed per OKDHS rules.* ☐ Other:	$

Explain how OKDHS and the adoptive family agreed upon the requested monthly amount:

	Benefits requested	Monthly amount requested
Adoptive name:	☐ Medicaid ☐ Monthly payment ☐ Special services ☐ Employment-related child care ☐ Non-recurring adoption expenses – *Not to exceed current amounts allowed per OKDHS rules.* ☐ Other:	$

Explain how OKDHS and the adoptive family agreed upon the requested monthly amount:

7. Post-finalization adoption assistance request – *For CFSD Post Adoptions Section use only*

A child may be eligible for Title IV-E post adoption assistance when the adoptive parent prevails in a fair hearing and proves, per OAC 340:75-15-128.5, that an extenuating circumstance exists.

When the request is due to a causative, pre-existing condition that was not identified or known prior to the legal adoption, attach current documentation of the treatment provided. NOTE: Attach a copy of final decree of adoption.

Child's adoptive name	Date of adoptive finalization	Explain justification for post-finalization request per OAC 340:75-15-128.4

8. Annual adoption assistance benefit need and review

☐ I am unable to adopt the child without adoption assistance.

☐ I understand that OKDHS conducts an annual review when adoption assistance benefits are provided and will require me to complete and return Form 04AN014E, Adoption Assistance Annual Review, each year benefits are received.

☐ I understand, when I receive adoption assistance benefits I am required to:

(1) inform OKDHS when circumstances occur that make the child ineligible for assistance payments or eligible for assistance payments in a different amount; and

(2) provide assurance annually that each child, who has attained the minimum age for compulsory school attendance under state law of the child's state of residence is:

(A) enrolled in an institution which provides elementary or secondary education as determined under the law of the state or other jurisdiction in which the institution is located;

(B) instructed in elementary or secondary education at home in accordance with a home school law or other jurisdiction in which the home is located;

(C) in an independent study elementary or secondary education program in accordance with the law of the state or other jurisdiction in which the program is located, which is administered by the local school or school district; or

(D) incapable of attending school on a full-time basis due to a documented medical condition supported by regular updates.

☐ I understand an agreement for adoption assistance must be signed ***prior*** to the final decree of adoption per federal and state law and OKDHS rules. I further understand I have a right to an administrative fair hearing if my application is denied, not acted on with reasonable promptness, approved in an amount less than requested, modified without my concurrence, or terminated.

Adoptive father's signature _____ Date _____

Adoptive mother's signature _____ Date _____

9. Required attachments:

☐ original and copy of Post Adoption Services Health Benefits Information;
☐ when requesting difficulty of care (DOC), medical or therapist report with copy of DOC guidelines per OKDHS Appendix C-20, Children and Family Services Division Rates Schedule, with criteria highlighted that best describes the child's needs;
☐ copy of adoptive parent's Social Security card;
☐ copy of petition for adoption, when filed;
☐ criminal background check results;
☐ documentation required in Section 4. Special needs determination; and
☐ Supplemental Security Income (SSI) award letter, when applicable.

Tribes include:

☐ cover letter requesting adoption assistance;
☐ copy of court order verifying tribal custody;
☐ copy of termination of parental rights (TPR) court order;
☐ Adoption and Foster Care Analysis and Reporting System (AFCARS) form; and
☐ child abuse and neglect reports.

SWIFT include:

☐ copy of TPR or KIDS TPR screenprint;
☐ copy of the court order removing the child(ren);
☐ copy of Form 04AN022E, Child Profile Assessment for Adoption; and
☐ Form 04AF007E, Records Check Documentation Form.

Private agencies include:

☐ cover letter requesting adoption assistance;
☐ copy of court order placing child with agency;
☐ copy of termination of parental rights order and relinquishment documents when applicable;
☐ Adoption and Foster Care Analysis and Reporting System (AFCARS) form; and
☐ child abuse and neglect reports.

10. Committee recommendations – *For CFSD Post Adoption Section use only*

Benefit	**Verification**
Title IV-E/foster care ☐ Yes ☐ No	

Comments:

Benefit	**Verification**
SSI ☐ Yes ☐ No	

Comments:

_____

Benefit	**Verification**
Other benefits: ☐ Yes ☐ No	

Comments:

Benefit	**Verification**
Other: ☐ Yes ☐ No	

Comments:

☐ **Agreement only -** No adoption assistance benefits provided at this time, but may be provided in the future if needed for child:

☐ **Agreement only -** No adoption assistance benefits provided at this time, but may be provide in the future if needed for child:

☐ **Agreement only -** No adoption assistance benefits provided at this time, but may be provide in the future if needed for child:

☐ **Agreement only -** No adoption assistance benefits provided at this time, but may be provide in the future if needed for child:

Child	Eligible/benefits recommended	Amount	Special services
	☐Medicaid ☐Non-recurring adoption expenses ☐Monthly payment ☐Special services		

Comments:

_____

Child	Eligible/benefits recommended	Amount	Special services
	☐Medicaid ☐Non-recurring adoption expenses ☐Monthly payment ☐Special services		

Comments:

Child	Eligible/benefits recommended	Amount	Special services
	☐Medicaid ☐Non-recurring adoption expenses ☐Monthly payment ☐Special services		

Comments:

Child	Eligible/benefits recommended	Amount	Special services
	☐ Medicaid ☐ Non-recurring adoption expenses ☐ Monthly payment ☐ Special services		

Comments:

11. Benefits decision

☐ Approved as recommended

☐ Approved as modified

☐ Disapproved

Comments:

CFSD representative _____ Date _____

CFSD representative _____ Date _____