**Annual Medicaid Redetermination / Information Update**

***Directions: Please complete each section thoroughly, sign and return within 10 days. Thank you!***

|  |  |  |
| --- | --- | --- |
| Date mailed by Department: |  |  |

**FAMILY INFORMATION**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  |  |  |  |  |

Family Last Name Father’s NameMother’s Name

|  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Physical Address: | |  | | | City/State: | |  | | | Zip: |  |
| Mailing Address: | |  | | | City/State: | |  | | | Zip: |  |
| Home Phone: |  | | Mobile  Phone: |  | Work  Phone: |  | | E-mail address: |  | | |

**PLEASE PROVIDE INFORMATION BELOW FOR CHILDREN RECEIVING ADOPTION ASSISTANCE**

**Name of Child(ren)**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Child (1) |  | Age: |  | DOB: |  | Male | Female |
| Child (2) |  | Age: |  | DOB: |  | Male | Female |
| Child (3) |  | Age: |  | DOB: |  | Male | Female |
| Child (4) |  | Age: |  | DOB: |  | Male | Female |

1. Is this child **currently** residing in your home? If no, where is the child currently residing?

|  |  |  |  |
| --- | --- | --- | --- |
| Child (1)  Yes  No |  | DFCS Notified:  Yes  No |  |
| Child (2)  Yes  No |  | DFCS Notified:  Yes  No |  |
| Child (3)  Yes  No |  | DFCS Notified:  Yes  No |  |
| Child (4)  Yes  No |  | DFCS Notified:  Yes  No |  |
|  |  |  |  |

1. Has this child resided in your **home during the past year**? If not, where has the child resided?

|  |  |  |
| --- | --- | --- |
| Child (1)  Yes  No |  | DFCS Notified:  Yes  No |
| Child (2)  Yes  No |  | DFCS Notified:  Yes  No |
| Child (3)  Yes  No |  | DFCS Notified:  Yes  No |
| Child (4)  Yes  No |  | DFCS Notified:  Yes  No |
|  |  |  |

1. Is your child covered under any type of private insurance other than Adoption Assistance Medicaid? Does your child receive SSI? **Please send copy of insurance card with this form, if other than Medicaid.**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Child (1)  Medicaid  Private Provider Name: |  | Group ID#: |  | SSI: | $ |
| Child (2)  Medicaid  Private Provider Name: |  | Group ID#: |  | SSI: | $ |
| Child (3)  Medicaid  Private Provider Name: |  | Group ID#: |  | SSI: | $ |
| Child (4)  Medicaid  Private Provider Name: |  | Group ID#: |  | SSI: | $ |

1. Has this child’s adoption been finalized? If yes, what was the date of finalization? If no, when is the expected date for finalization?

|  |  |
| --- | --- |
| Child (1)  Yes  No |  |
| Child (2)  Yes  No |  |
| Child (3)  Yes  No |  |
| Child (4)  Yes  No |  |

**Please Note:** Your Adoption Assistance Agreement and State Policy require you to notify the Department of Family and Children Services within 10 days, in writing, of any of the following events: change of address; the child's death, marriage or entry into the military service; the child no longer attending school on a full-time basis after age 18 (if approved by the State for adoption assistance benefits past 18). Note: GED and Job Corps are not approved as forms of education after age 18. Additional changes/events that must be reported to DFCS in writing within 10 days include: the adoptive parent(s) no longer being legally or financially responsible for the support of the child; any report of substantiated child abuse or neglect or the temporary removal of the child from the home; the child no longer residing in the home. Failure to report such changes regarding children receiving Adoption Assistance may result in an overpayment of Federal and State funds. The family will be responsible for reimbursing the overpayment to the county department. If this results in unsuccessful collection, the Department shall have the authority to pursue other legal remedies.

Please use the space below to notify DFCS of changes, like the ones mentioned above, which might affect your child(ren)’s eligibility for adoption assistance. Also, please indicate any upcoming plans which might affect eligibility for adoption assistance:

|  |
| --- |
|  |
|  |
|  |
|  |
|  |
|  |

I / We acknowledge that all of the above information is true:

|  |  |  |
| --- | --- | --- |
|  |  |  |

Adoptive Father’s Signature Date Adoptive Mother’s Signature Date

Please use two of these forms if there are more than 4 children in the home receiving adoption assistance.

**RETURN THIS FORM AND COPIES OF ANY PRIVATE INSURANCE CARDS FOR CHILDREN RECEIVING ADOPTION ASSISTANCE TO THE DFCS CONTACT PERSON BELOW:**

|  |  |  |
| --- | --- | --- |
| RETURN TO: DFCS Regional PAD Manager  Name: | |  |
| Mailing Address: |  |
| FAX Number: |  |
| E-Mail Address: |  |
| Phone Number: |  |

THANK YOU.