



**GEORGIA DIVISION OF FAMILY AND CHILDREN SERVICES
ADOPTION ASSISTANCE MEMORANDUM**

**Adoption Services: FORM SECTION- FORM 403, ADOPTION
ASSISTANCE MEMORANDUM**

FORM 403

ADOPTION ASSISTANCE MEMORANDUM

INSTRUCTIONS

Form 403 is to be completed on every Adoption Assistance case at the time of initial approval, any subsequent approval for non-recurring expenses, and status/funding change of adoption assistance. In addition, the Form 403 must be used for Annual Medicaid Redetermination.

The form shall be completed as follows:

- **Check the type of adoption: State Agency Adoption (Child in DHS custody), a Private Agency Adoption (child in DHS custody), a Private Agency Adoption (child not in DHS custody), Or a Relative Adoption (child not in DHS custody)**
- **Complete identifying information on each child**
- **Sign and date form prior to submission to the Social Services Administration Unit, Regional Accounting, and REV MAX**
- **Complete Annual Medicaid Redetermination section when applicable**

The Adoption and Foster Care Analysis Reporting System (AFCARS) section must be completed for Federal reporting at the time of the initial approval on private and relative (independent) adoptions. Complete on all children as this data critically impacts DHS/DFCS funding.



GEORGIA DIVISION OF FAMILY AND CHILDREN SERVICES
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DATE: _____

TO: ☐ Social Services Administration Unit
☐ Regional Accounting
☐ Revenue Maximization Unit

From: _____
County DFCS

Caseworker

Telephone #

RE: _____
Family Name Father Mother Address

Child's Birth Name DOB Race Sex FC Medicaid # SSN

Child's name as it should appear on Medicaid Card post finalization: _____

Date of Finalization

New Medicaid Number

New Social Security #

BENEFITS

This child has been approved for adoption assistance benefits. The approval period begins ___/___/___ and ends the last day of the child's 18th birth month.

The child is eligible for the following:

☐ State Funded title IV-B Adoption Assistance: Amount \$_____ (UAS Code 508)

☐ Title IV-E Adoption Assistance: Amount \$_____ UAS Code 509)

☐ Non-recurring Adoption Assistance: Amount \$_____ Month Paid_____ (UAS Code 510)

Child Turning Age 18

Child meets criteria to continue adoption assistance benefits beyond age 18: ☐ Yes ☐ No.

Approval of Adoption Assistance beyond age 18 must be completed within 60 days prior to the child's 18th birth month. If approved, Adoption Assistance benefits shall begin the month immediately following the child's 18th birth month, and must be changed to Title IV-B funds, if not already Title IV-B.



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☐ Full time school attendance has been verified and documented. Verification is required each quarter/semester for the child to remain eligible.

Benefits Section Completed by: _____
Social Services Case Manager Date

Benefits Section Approved by: _____
Social Services Supervisor Date

MEDICAID ANNUAL REDETERMINATION

This child continues to receive adoption assistance benefits. ☐ Yes ☐ No

Child receives SSI? ☐ Yes ☐ No Amount of SSI? \$ _____

Child covered by adoptive parent(s)' insurance? ☐ Yes ☐ No If yes, please provide name of carrier and all identifying group and coverage information. Please provide copy of insurance card if available.

Name of Carrier: _____

Group Number: _____

Identification Number/Member ID: _____

Policy Holder: _____

Medicaid Section Completed by: _____
Social Services Case Manager Date

Medicaid Section Approved by: _____
Social Services Supervisor Date

STATUS CHANGE

☐ Family has moved to a new address, which is indicated above.
(If moving out of state, attach 402 with referral)

Effective: _____
Date

☐ Adoption Assistance (AA) Transfer: From: _____ Stop AA Payment Date: _____
County

To: _____ Start AA Payment Date: _____
County



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☐ **Terminate Adoption Assistance**

Adoption Assistance Payments should discontinue effective: _____ *Reason* _____
Date

Medicaid Benefits should discontinue effective: _____ *Reason* _____
Date

Reasons:

Child does not meet criteria for Adoption Assistance Past Age 18

Child over 18 and no longer in high school or college full-time

Child has reached age 21

Child over 18 and has completed high school or college

Child deceased

Adoptive parent(s) deceased

Verification of family's legal and financial responsibility cannot be established

Disruption/Dissolution

Status Change Section Completed by: _____
Social Services Case Manager Date

Status Change Section Approved by: _____
Social Services Supervisor Date

Adoption and Foster Care Analysis and Reporting System (AFCARS)
INFORMATION FOR FEDERAL REPORTING

CHILD

☐ **Child is Special Needs**

Primary Special Need
0=Non Special Needs
1=Racial Background
2=Age
3=Sib Group To Be Placed Together
4=Medical Mental, Physical or Emotional Disabilities
5=Other

☐ **Mental Retardation**
☐ **Visually or Hearing Impaired**
☐ **Physically Disabled**
☐ **Emotionally Disturbed**
☐ **Other medical Condition Requiring Special Care**

Severity

<input type="radio"/> Mild	<input type="radio"/> Moderate	<input type="radio"/> Severe
<input type="radio"/> Mild	<input type="radio"/> Moderate	<input type="radio"/> Severe
<input type="radio"/> Mild	<input type="radio"/> Moderate	<input type="radio"/> Severe
<input type="radio"/> Mild	<input type="radio"/> Moderate	<input type="radio"/> Severe
<input type="radio"/> Mild	<input type="radio"/> Moderate	<input type="radio"/> Severe

Birth Parents

Mother

Date of Birth

Race

Father

Date of Birth

Race

Birth Mother Rights Terminated

Date

Birth Father Rights Terminated

Date

☐ **Mother Married at time of child's birth**

Family Structure

☐ **Married Couple** ☐ **Single Female** ☐ **Single Male**

Birth Mother Right Termination Type

Birth Father Rights Termination Type

Check one: ☐ Court ☐ Voluntary ☐ Deceased

Check one: ☐ Court ☐ Voluntary ☐ Deceased

☐ **Of Hispanic origin** ☐ **Non Hispanic** ☐ **Unable to determine**

Adoptive Parents

Adoptive Mother

Date of Birth

Race

☐ **Of Hispanic origin**

☐ **Non Hispanic**

Adoptive Father

Date of Birth

Race

☐ **Unable to determine**

Child Placed From:

☐ **Within State**
☐ **Another State**
☐ **Another County**

Adoptive Parent is:

☐ **Step-Parent**
☐ **Other Relative**
☐ **Foster Parent**
☐ **Non Relative**
☐ **Birth Parent**

Child Placed By:

☐ **Public Agency**
☐ **Private Agency**
☐ **Tribal Agency**
☐ **Independent Agency**

Adoption Finalized

Date