EDUCATION & TRAINING
Services Section

GEORGIA DEPARTMENT OF HUMAN RESOURCES
DIVISION OF FAMILY & CHILDREN SERVICES

Adoption Assistance

Participant's Guide

DHR

This curriculum focuses on the legal and practice implications of the state and federally funded adoption assistance program.

Module One
Introduction

ADOPTION ASSISTANCE and POST ADOPTION SERVICES TRAINING FOR SOCIAL SERVICES

PURPOSE: increase knowledge of the state and federally funded adoption assistance program. To gain an understanding of the legal and practice implications for adoption assistance and post adoption services.

OBJECTIVES:

- Recognize the differences between state and federal (Title IVE) eligibility requirements
- Distinguish between the requirements of Title IVE foster care and Title IVE adoption assistance
- Gain knowledge of AA policy and procedures for all components of the program
- Demonstrate the ability to complete and process forms for all benefit programs under Adoption Assistance
- Gain an understanding of the legal ramifications for failure to follow policy (state and federal)
- Gain knowledge of existing available post adoption services to families

AGENDA

Welcome and Introductions
Training Overview

I. Introduction

What is Adoption Assistance?

Types of Benefits

Legal Underpinnings

II. Getting Started

Special Needs Determination

Specialized Adoption Assistance

Revenue Maximization

III. Title IVE Adoption Assistance

What are the Differences between IVE Foster Care and IVE Adoption Assistance?

Determining IVE Eligibility-How Do You Know?

Adoption by a Specified Relative

IV. Recurring/ Monthly Adoption Assistance

Keeping the Family Informed

Assessing/Negotiating the Agreement

Role Play

Signing the Agreement

Completing the Adoption Assistance Package

Deferred Adoption Assistance Agreements

V. Additional Benefits and Their Duration

Medicaid, Non-recurring Adoption Assistance and Special Services

Completing Forms

Duration of Benefits

Renewals-Adoption Assistance and Medicaid

VI. Special Considerations

Things to remember

Transferring Cases

VII. Post Adoption Services

What Services May a Family Receive after Finalization?

How do You Access These Services?

VIII. Post Finalization and Fair Hearing Requests

What are Grounds for a Fair Hearing?

How Do You Process a Request?

WHAT IS ADOPTION ASSISTANCE?

Adoption Assistance is a financial and medical benefit that is available to adopted children. The purpose of the adoption assistance program is to assist adoptive families in providing a safe and supportive environment for a child placed in their home and to help in meeting the special needs of the child. Adoption Assistance should not be confused with a foster care per diem.

Not all children are eligible to receive these benefits which is perhaps why the concept of adoption assistance is confusing at times. The main "door" that must be opened and is considered a starting point of eligibility is the requirement that a child is one who has **special needs**.

LEGAL UNDERPINNINGS OF ADOPTION ASSISTANCE

The Adoption Assistance program has its roots in both state and federal law. The following two laws were the initial laws
that instituted the adoption assistance program:

The Children and Youth Act of 1973 was the first law regarding adoption assistance in the state of Georgia. This law made possible a completely state funded adoption assistance program that was available to a very small number of special needs adopted children. This particular program was the only one available to adopted children until the federal program came into being seven years later.

The Adoption Assistance and Child Welfare Act of 1980, also known as PL 96-272, was the resulting federal legislation. Following this legislation, all states were eligible for federal financial participation for children who met Title IVE criteria.

Since 1980 there have been additions and modifications to the AA program, either through new laws (ie. ASFA) or through changes to the existing legislation (ie. Non-recurring adoption expenses).

TYPES OF BENEFITS

Benefits are for special needs children only.

There are four benefit categories under the Adoption Assistance program.

Each benefit has its own eligibility requirements. Medicaid and recurring/monthly benefits are always from the same funding source, either state or federal funds.

Monthly (recurring) Adoption Assistance: These benefits are based on the needs of child and are available up to the amount of the family foster care rate the child was receiving at the time of adoptive placement. These benefits are fixed and increases will not be provided unless the state decides to provide cost of living increases for recipients. It is important to assess the needs of the child and determine whether or not the child is receiving a family foster care benefit based on these needs. These rates include the specialized foster care rates, but not level of care.

Funding source for these benefits is either state funds or Title IVE funds.

Medicaid: Medical benefits provided under the state Medicaid program are available to any child who receives adoption assistance (unless ineligible based on income or legal status).

Funding source is either state funds or Title IVE funds.

Non-recurring Adoption Expenses: These are the expenses related to the finalization of the adoption. They may be paid directly or the family may be reimbursed, but no benefits are payable unless the adoption finalizes. The maximum amount is $2,000 per child.

Funding source is Title IVE funds.

Special Services Adoption Assistance: This is a limited funding source available to children in need of additional services to meet their special needs that are not covered by the monthly/recurring assistance, Medicaid or through other community or family resources.

Funding source is state funds.

Module Two
Getting Started

SPECIAL NEEDS DETERMINATION: THREE PRONGS

PRONG ONE: At the time of adoptive placement, the child must meet the state's definition of special needs.

- any child eight (8) years of age or older
- any child of African American heritage: one (1) year of age or older
- members of a sibling group of three (3) or more to be placed together
- members of a sibling group of two (2) where one is over eight (8) or has another special need
- any child with documented physical, emotional or mental problems or limitations

PRONG TWO: The state must determine the child cannot or should not be returned home to his parents. (This may be by virtue of a TPR or Voluntary Relinquishment)

PRONG THREE: A reasonable but unsuccessful effort must be made to place the child without adoption assistance. (This may be achieved by asking the prospective adoptive family if they are able to adopt the child without any assistance. This may also be accomplished by indicating the child is registered in the State Adoption Exchange or that the child is being adopted by a foster parent or someone with whom he or she has significant emotional ties.)

SPECIAL NEEDS DETERMINATION

Procedure:

SSCM will request a special needs determination from the State Adoption Unit prior to adoptive placement and prior to discussing a child with a prospective adoptive parent.

Submit Form 400 and any current documentation from a provider (within the past six months) regarding the child's medical, psychiatric, developmental, etc. condition. All children must have a special needs determination even if 'special needs' by definition, i.e. a sibling group of three being placed together in the same home.

The SAU will provide a Memorandum indicating whether or not a child is determined special needs for the purpose of adoption assistance. If a child is not special needs but has background factors only, a deferred adoption assistance agreement package shall be completed and kept on-file in the SAU.

(Adoption Policy Manual Section 109.3)

Georgia Department of Human Resources

ADOPTION EXCHANGE REGISTRATION CHILD

STATE OFFICE USE

DATE RECEIVED

Notification	☐
Registration	☐
Update	☐
Re-Registration	☐
Closure	☐

Member of sibling group free for adoption? ☐ Yes ☐ No	# in sibling group free for adoption	Place together? ☐ Yes ☐ No	Number to be placed with this child, including this child:
Child's first name:		Child's last name:	
DOB:	Sex: ☐ M ☐ F	Race/Ethnic: ☐ Black ☐ Black/White ☐ Black/Other ☐ Mixed/Other ☐ Hispanic ☐ Indochinese ☐ White ☐ Native American ☐ Native American /Other	IV-E Eligible? ☐ Yes ☐ No
Home county name:		Boarding county name:	
Last entry date into foster care:		Was mother married at the time child born? ☐ Yes ☐ No	
Life history approval date:			
Disruption? ☐ Yes ☐ No	Date:	Picture/Summary for My Turn Now? ☐ Yes ☐ No	
Dissolution? ☐ Yes ☐ No	Date:	Closure date and reason:	

SPECIAL NEEDS (See Page 2 Special Needs Categories-Definitions) **For Matching Purposes Only**

Does the child have one of the following special needs as diagnosed by a professional? If yes, indicate degree

Special Needs	YES	NO	Mild	Moderate	Severe	**Background Factors**	YES	NO
Mental Retardation	☐	☐	☐	☐	☐	Family Hx of Drugs/Alcohol	☐	☐
Visual/Hearing	☐	☐	☐	☐	☐	Family Hx of Mental Illness	☐	☐
Medical Diagnosis	☐	☐	☐	☐	☐	Family Hx of Mental Retardation	☐	☐
Emotionally Disturbed	☐	☐	☐	☐	☐	Sexual Abuse History	☐	☐
Developmental Delay	☐	☐	☐	☐	☐	Legal Risk	☐	☐
Neurological Impairment	☐	☐	☐	☐	☐			

Child Status: Family identified? ☐ Yes ☐ No		If sibling group is to be divided, indicate by name how this will be done:			
If yes: County/Private Agency name:					
Family name:					
Assessment registered?	☐ Yes ☐ No				
If no, completion date:		**TERMINATION STATUS**			
Is this an ICPC placement?	☐ Yes ☐ No	Mother	VR ☐ CO ☐ Date:	DOB:	Race:
TYPE OF IDENTIFIED HOME-CHECK **ONE**		Father (Bio/Legal)	VR ☐ CO ☐ Date:	DOB:	Race:
Regular Adoptive Home	☐	Biological Father	VR ☐ CO ☐ Date:	DOB:	Race:
Foster/Adoptive Home	☐	Legal Father	VR ☐ CO ☐ Date:	DOB:	Race:
Foster Parent	☐	Guardian	VR ☐ CO ☐ Date:	DOB:	Race:
Relative Foster Home	☐	Is an appeal pending? ☐ Yes ☐ No		Hearing Date:	
Relative, not Foster Parent	☐	If all rights NOT terminated, action expected by date:			

Date	Worker Name and Title	Worker Phone Number

Georgia Department of Human Resources
ADOPTION EXCHANGE REGISTRATION
CHILD

SPECIAL NEEDS CATEGORIES-DEFINITIONS
Mental Retardation **Mild**: IQ range 50-75 **Moderate**: IQ range 25-50 **Severe**: IQ range less than 25
Visual/Hearing Impairments **Mild**: sight in both eyes but special glasses are required; partial hearing that is correctible with aides **Moderate**: uncorrectable partial hearing or vision problems **Severe**: Deafness or Blindness
Medical Diagnosis **Mild**: conditions that cause slight impairment and require limited treatment (anemia, deformed limb, arthritis, mild progressive disorders) **Moderate**: conditions that cause moderate limitations and require on-going treatment (Crohn's disease, diabetes, HIV+, kidney disease, lupus, fetal alcohol syndrome, asthma, sickle cell disease, scoliosis, missing limbs) **Severe**: potentially fatal conditions that require long term treatment (quadriplegia, muscular dystrophy, cystic fibrosis, AIDS, leukemia, cancer, multiple moderate problems)
Emotional/Behavioral **(requires DSM-IV diagnosis)** **Mild**: conditions that respond to short-term treatment (situational depression, adjustment disorders) **Moderate**: chronic conditions that require ongoing intervention (reactive attachment disorder, anxiety disorder, mood disorders [major depression, bipolar disorder], oppositional defiant disorder) **Severe**: conditions that require residential treatment or other intensive interventions (psychotic disorders, dissociative disorders, life threatening eating disorders, conduct disorder)
Developmental delay **Mild**: conditions that are correctable or require limited treatment (mild learning disorders, developmental disorders that are resolved by pre-school intervention) **Moderate**: chronic conditions that require frequent intervention (significant learning disorders, pervasive developmental disorder, Asperger's disorder) **Severe**: conditions that require intensive management (autistic disorder, multiple moderate conditions)
Neurological Impairments **Mild**: conditions that cause slight impairment and require limited treatment (medication controlled epilepsy, migraine headaches, mild cerebral palsy) **Moderate**: conditions that cause moderate limitations and require on-going treatment (multiple sclerosis, moderate cerebral palsy, ADHD) **Severe**: conditions that require long term treatment (multiple moderate problems)

DHR

B.J. Walker, Commissioner

Georgia Department of Human Resources • Division of Family and Children Services • Adoption Unit
2 Peachtree Street, N.W • Suite 8-400 • Atlanta, GA 30303-3142 • Phone: 404-657-3550 • Fax: 404-657-9498

MEMORANDUM

TO: County Director
Terrell County DFCS

FROM: Adrian J. Owens
Policy Specialist
Post Adoption Services

RE: **Jane Doe** **DOB: 12/29/2005**

DATE: December 29, 2005

This child (is) (is not) registered as a child with special needs for the purpose of Adoption Assistance based on age.

If this child has background factors only, have the family sign a deferred Adoption Assistance Agreement to be kept on file. Please inform the family that future consideration for Adoption Assistance will be determined by the State Adoption Unit.

cc: Adrian Owens

(Manual Reference: 109.3)

Specialized Rates for Adoption Assistance

When submitting a request for a higher amount of assistance, the following information shall be included in the packet:

- Current documentation from the treatment provider that identifies the child's treatment needs, progress and prognosis. (Information should be current within the most recent six month period)
- Psychological evaluation completed within two years if the special needs are based on the child's psychological diagnosis and behaviors.
- MPI 1(Bubble Sheet)
- DHR LOC/SFC Application:
  - Cover Sheet
  - Application Instructions
  - Attachment 1 Placement Treatment History
  - Attachment 4 Caregiver Assessment Form
  - Attachment A SFC Memo
  - Attachment B SFC Memo
  - Checklist
- Documentation of application for SSI when the child is not IV-E and the special needs are severe enough to qualify for SSI benefits.
- A copy of the most recent Specialized DFCS Family Foster Care determination or Level of Care. Forms for application may be downloaded from the following site: www.galocweb.com.

(Adoption Policy Manual Section 109.8)

DHR
Georgia Department of Human Resources

MATCH Profile Instrument
Part I

DJJ
Georgia Department of Juvenile Justice

Type of Application

- ☐ Basic Group Care (IFC)
- ☐ Level of Care
  - ☐ Medically Fragile
  - ☐ Seriously Emotionally Disturbed
- ☐ MATCH
- ☐ DJJ - Specialized Treatment Services

IMPORTANT DIRECTIONS FOR MARKING ANSWERS

- Use a #2 pencil only.
- Do NOT use ink or ball point pens.
- Make heavy black marks that fill the circle completely.
- Erase cleanly any answer you wish to change.
- Make no stray marks on the answer sheet.

Correct mark ■ Incorrect marks ✓ ✗ ● ▬

1. Child's Legal Name (write name above bubble area)

Last Name | First Name | MI

2. Today's Date M M D D Y Y

3. Social Security No. – –

4. Gender

- ☐ Female
- ☐ Male

5. Ethnicity:

- ☐ White
- ☐ Black/African American
- ☐ American Indian/Alaskan
- ☐ Asian or Pacific Islander
- ☐ Hispanic
- ☐ Multi-racial
- ☐ Unable to determine

6. Date of Birth M M D D Y Y

7. Religion

- ☐ Protestant
- ☐ Catholic
- ☐ Jewish
- ☐ Muslim
- ☐ No Affiliation
- ☐ Other:_____

8. Legal custodian (relationship to child)
Mark only one:

- ☐ Biological parent(s)
- ☐ Adoptive parent(s)
- ☐ DFCS
- ☐ Other:_____

Please report DJJ commitment in #24

9. County of legal custodian

Please see county code list for code

10. Is there a relative, foster family, or other visiting resource?

- ☐ Yes
- ☐ No

11. Mother's rights terminated or relinquished:

- ☐ Yes
- ☐ No

12. Father's rights terminated or relinquished:

- ☐ Yes
- ☐ No

SCANTRON® FORM NO. F-11639-GDHR M 2 4098-282-12 11 10 9 8 7 6 5 4 3

FINANCIAL INFORMATION

13. Medicaid:
- ☐ Yes
- ☐ No

If "no", date applied: _____

14. IV-E Eligible
- ☐ Yes
- ☐ No

15. SSI
- ☐ Yes
- ☐ No

If "no", date applied: _____

16. Peach Care
- ☐ Yes
- ☐ No
- ☐ Applied

17. Other sources of income available (mark all that apply)
- ☐ Family Income
- ☐ Social Security/Death Benefits/Disability/Retirement
- ☐ Child Support
- ☐ Adoption Supplement
- ☐ Veterans Benefit
- ☐ Other _____

AGENCY INVOLVEMENT

18. Referring Agency type:
- ☐ DFCS
- ☐ DJJ
- ☐ MHMRSA

19. Referring Agency name: _____

Referring Agency address: _____

City/Zip: _____

Phone: _____

Fax: _____

20. Referring Case manager: _____

21. Agency(ies) currently serving child (mark all that apply)
- ☐ DFCS
- ☐ DJJ
- ☐ Community Mental Health, Mental Retardation, Substance Abuse
- ☐ Independent Juvenile Court
- ☐ Private mental health providers

JUVENILE JUSTICE INVOLVEMENT

22. History of involvement with Juvenile Justice:
- ☐ Yes
- ☐ No

23. Current involvement:
- ☐ Yes (if yes, complete #24)
- ☐ No

24. Current Juvenile Justice Disposition (mark all that apply):
- ☐ Commitment to DJJ
- ☐ Probation
- ☐ Sentenced to Boot Camp
- ☐ Informal Adjustment
- ☐ Pending

SUBSTANCE ABUSE

25. Does the child experiment with or use alcohol and/or drugs?
- ☐ Yes
- ☐ No
- ☐ Unknown

26. Has the child received treatment for alcohol or drug abuse?
- ☐ Yes
- ☐ No
- ☐ Unknown

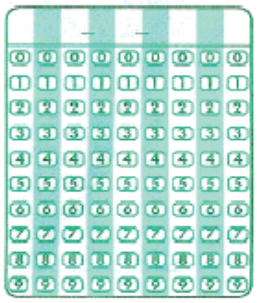
HISTORY OF MALTREATMENT

27. History of maltreatment (mark all that apply):
- ☐ Neglect
- ☐ Emotional abuse
- ☐ Physical abuse
- ☐ Sexual abuse
- ☐ Suspected or alleged abuse/neglect
- ☐ None

28. Parental/Caregiver Issues (mark all that apply)
- ☐ Criminality
- ☐ Current incarceration
- ☐ Mental illness/Mental retardation
- ☐ Family Violence
- ☐ Suicide attempts
- ☐ Death resulted from suicide or homicide
- ☐ Substance abuse
- ☐ Childhood maltreatment of parent(s)

Name: _____

Social Security No.



PHYSICAL HEALTH

29. Diagnosed Physical Conditions (mark all that apply):

- ☐ Anemia
- ☐ Sickle Cell Anemia
- ☐ Severe Allergies
- ☐ Rheumatic Fever, Heart Disease, Heart Murmur
- ☐ Epilepsy (seizure disorder)
- ☐ Tuberculosis
- ☐ Diabetes
- ☐ Cancer
- ☐ Asthma
- ☐ Eczema
- ☐ AIDS
- ☐ HIV
- ☐ Herpes
- ☐ Hepatitis
- ☐ Other: _____

EDUCATIONAL INFORMATION

30. Status of Current School Placement:

- ☐ Public school ☐ Private school
  - ☐ Regular classes
  - ☐ Alternative school
  - ☐ Special education classes (mark all that apply)
    - ☐ Psycho educational placement
    - ☐ Self contained classroom
    - ☐ Resource or other special educational placement
    - ☐ Gifted
    - ☐ Learning disability
    - ☐ Emotional behavioral disorder/ Severe emotional disturbance
    - ☐ Mild intellectual disability
    - ☐ Moderate intellectual disability
    - ☐ Severe intellectual disability
    - ☐ Profound intellectual disability
    - ☐ Orthopedic impairment
    - ☐ Other health impairment
    - ☐ Speech-language impairment
    - ☐ Deaf/Blind
    - ☐ Hearing impairment
    - ☐ Significant developmental delay
    - ☐ Visual impairment
    - ☐ Traumatic brain injury
    - ☐ Autism
- ☐ Expelled

EVALUATION INFORMATION

31. Speech and Language

Problem identified ☐ Yes ☐ No

Evaluation completed ☐ Yes ☐ No

32. Adaptive Behavior Scale

(1) Vineland (2) American Association of Mental Retardation Adaptive Behavior Scales Revised (ABS-RC:2)

(3) Other _____

Test #	Composite Score
1	0 0 0
2	1 1 1
3	2 2 2
	3 3 3
	4 4 4
	5 5 5
	6 6 6
	7 7 7
	8 8 8
	9 9 9

Date completed

M M	D D	Y Y
0 0	0 0	0 0
1 1	1 1	1 1
	2 2	2 2
	3 3	3 3
		4 4
		5 5
		6 6
		7 7
		8 8
		9 9

33. IQ Score (1) Stanford Binet (2) Kaufman Brief Intelligence Test (K-Bit) (3) Weschler Intelligence Scale for Children (WISC) (4) Weschler Adult Intelligence Scale (WAIS) (5) Other_____

Test #	Full Scale Score	Verbal Score	Performance Score
1	0 0 0	0 0 0	0 0 0
2	1 1 1	1 1 1	1 1 1
3	2 2 2	2 2 2	2 2 2
4	3 3 3	3 3 3	3 3 3
5	4 4 4	4 4 4	4 4 4
	5 5 5	5 5 5	5 5 5
	6 6 6	6 6 6	6 6 6
	7 7 7	7 7 7	7 7 7
	8 8 8	8 8 8	8 8 8
	9 9 9	9 9 9	9 9 9

Date completed

M M	D D	Y Y
0 0	0 0	0 0
1 1	1 1	1 1
	2 2	2 2
	3 3	3 3
		4 4
		5 5
		6 6
		7 7
		8 8
		9 9

34. Achievement Test Score

(1) Woodcock Johnson (WJR) (2) Wechsler (WIAT)

(3) Peabody (PIAT) (4) Wide Range Achievement Test (WRAT)

(5) Kaufman Test of Educational Achievement (KTEA)

(6) Other _____

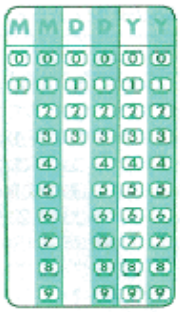
Test #	Reading		Math	
	Standard Score	Grade Level	Standard Score	Grade Level
1	0 0 0	0 0 . 0	0 0 0	0 0 . 0
2	1 1 1	1 1 . 1	1 1 1	1 1 . 1
3	2 2 2	2 2 . 2	2 2 2	2 2 . 2
4	3 3 3	3 3 . 3	3 3 3	3 3 . 3
5	4 4 4	4 4 . 4	4 4 4	4 4 . 4
6	5 5 5	5 5 . 5	5 5 5	5 5 . 5
	6 6 6	6 6 . 6	6 6 6	6 6 . 6
	7 7 7	7 7 . 7	7 7 7	7 7 . 7
	8 8 8	8 8 . 8	8 8 8	8 8 . 8
	9 9 9	9 9 . 9	9 9 9	9 9 . 9

Date completed

M M	D D	Y Y
0 0	0 0	0 0
1 1	1 1	1 1
	2 2	2 2
	3 3	3 3
		4 4
		5 5
		6 6
		7 7
		8 8
		9 9

35. Most Current Diagnoses: (use "other diagnosis" or "rule out diagnosis" as needed)

Date of diagnosis:



Disorders of Infancy, Childhood & Adolescence:

- ☐ Asperger's Disorder (299.80)
- ☐ Pervasive Developmental Disorder NOS (299.80)
- ☐ Attention Deficit/Hyperactivity Disorder (314.0)
- ☐ Conduct Disorder (312.8)
- ☐ Oppositional Defiant Disorder (313.81)
- ☐ Tourette's Disorder (307.23)
- ☐ Enuresis (not due to medical condition) (307.6)
- ☐ Encopresis - With Constipation (786.7)
- ☐ Encopresis - Without Constipation (307.7)
- ☐ Separation Anxiety Disorder (309.21)
- ☐ Reactive Attachment Disorder (313.89)
- ☐ Disruptive Behavior Disorder (312.9)
- ☐ Mild Mental Retardation (317)
- ☐ Moderate Mental Retardation (318.0)
- ☐ Severe Mental Retardation (318.1)

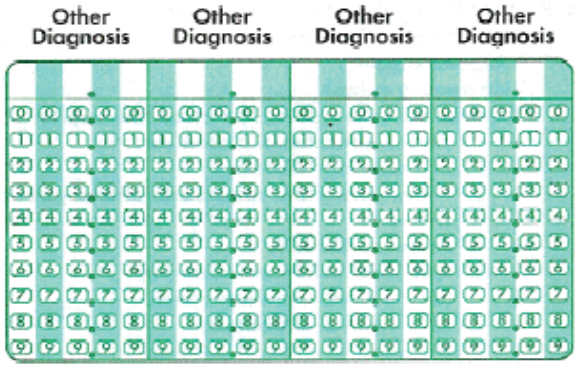
Cognitive Disorders:

- ☐ Cognitive Disorder NOS (294.9)

Substance Use Disorders:

- ☐ Alcohol Abuse (305.00)
- ☐ Other or Unknown Substance Abuse (305.90)

Other Current Diagnoses



Schizophrenia & Other Psychotic Disorders:

- ☐ Schizophrenia, Paranoid type (295.30)
- ☐ Schizophrenia, Undifferentiated Type (295.90)
- ☐ Schizoaffective Disorder (295.70)
- ☐ Psychotic Disorder NOS (298.9)

Mood Disorders:

- ☐ Bipolar Disorder NOS (296.8)
- ☐ Depressive Disorder NOS (311)
- ☐ Major Depressive Disorder, Single Episode (296.2)
- ☐ Major Depressive Disorder, Recurrent Episode (296.3)
- ☐ Dysthymic Disorder (300.4)
- ☐ Mood Disorder NOS (296.9)

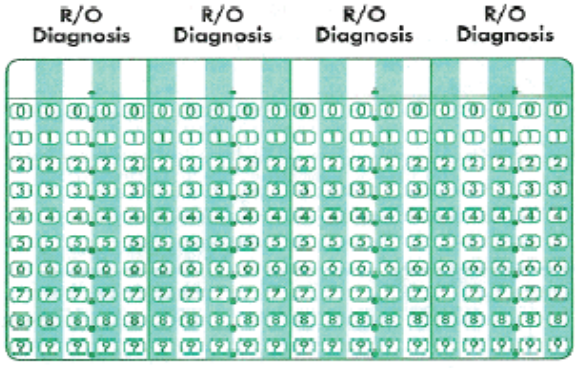
Anxiety Disorders:

- ☐ Posttraumatic Stress Disorder (309.81)
- ☐ Generalized Anxiety Disorder (includes Overanxious Disorder of Childhood)(300.02)
- ☐ Anxiety Disorder NOS (300.00)

Sexual and Gender Identity Disorders:

- ☐ Paraphilia NOS (302.9)
- ☐ Gender Identity Disorder NOS (302.6)
- ☐ Sexual Disorder (302.9)

Other Current Rule Out Diagnoses



Eating Disorders:

- ☐ Eating Disorder NOS (307.50)
- ☐ Anorexia Nervosa (307.1)
- ☐ Bulimia Nervosa (307.51)

Impulse Control Disorders:

- ☐ Intermittent Explosive Disorder (312.34)
- ☐ Impulse Control Disorder NOS (312.30)

Adjustment Disorders:

- ☐ Adjustment Disorder with Depressed Mood (309.0)
- ☐ Adjustment Disorder with Anxiety (309.24)
- ☐ Adjustment Disorder with Disturbance of Conduct (309.3)
- ☐ Adjustment Disorder with Mixed Disturbance of Emotions and Conduct (309.4)

Personality Disorders:

- ☐ Personality Change due to Medical Condition (310.1)
- ☐ Antisocial Personality Disorder (301.7)
- ☐ Borderline Personality Disorder (301.83)
- ☐ Histrionic Personality Disorder (301.50)
- ☐ Narcissistic Personality Disorder (301.81)

36. Current placement

- ☐ Jail
- ☐ State Mental Hospital
- ☐ County Detention Center
- ☐ Youth Correctional Center
- ☐ Intensive Treatment Unit
- ☐ Drug/Alcohol Rehab Center
- ☐ Medical Hospital (Inpatient)
- ☐ Wilderness Camp (24hr)
- ☐ Residential Treatment Center
- ☐ Group Emergency Shelter
- ☐ Residential Job Corps Center
- ☐ Group Home
- ☐ Foster Family Treatment
- ☐ Home Emergency Shelter
- ☐ Specialized Foster Care
- ☐ Regular Foster Care
- ☐ Supervised Independent Living
- ☐ Home of Family Friend
- ☐ Adoptive Home
- ☐ Home of Relative
- ☐ School Dormitory
- ☐ Natural Parent(child)
- ☐ Natural Parents (age 18)
- ☐ Independent Living with Friend
- ☐ Independent Living by Self

37. Date Local MATCH Staffing

M	M	D	D	Y	Y
0	0	0	0	0	0
1	1	1	1	1	1
	2	2	2	2	2
	3	3	3	3	3
	4		4	4	4
	5		5	5	5
	6		6	6	6
	7		7	7	7
	8		8	8	8
	9		9	9	9

Recommendation

- ☐ Intensive
- ☐ Intermediate
- ☐ Therapeutic Foster Care
- ☐ Other _____

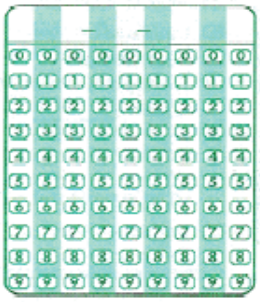
Remember, mark only one box for each behavior.

Child's Name _____ Behaviors	N/A	Mark if by History	Has behavior occurred within past year? If yes, mark severity. Mild	Moderate	Severe	Except where behavior is not applicable, give description of behavior.
1. Difficulty concentrating, easily distracted.	☐	☐	☐	☐	☐	
2. Can't sit still, is restless.	☐	☐	☐	☐	☐	
3. Impulsive, acts before thinking.	☐	☐	☐	☐	☐	
4. Underactive, lacks energy	☐	☐	☐	☐	☐	
5. Acts disobediently at home.	☐	☐	☐	☐	☐	
6. Acts disobediently at school.	☐	☐	☐	☐	☐	
7. Demands attention.	☐	☐	☐	☐	☐	
8. Associates with children who get into trouble.	☐	☐	☐	☐	☐	
9. Doesn't get along well with other children.	☐	☐	☐	☐	☐	
10. Is bullying or mean.	☐	☐	☐	☐	☐	
11. Gets into fights.	☐	☐	☐	☐	☐	
12. Lies and/or cheats.	☐	☐	☐	☐	☐	
13. Feels no guilt after misbehaving.	☐	☐	☐	☐	☐	
14. Runs away.	☐	☐	☐	☐	☐	
15. Has volatile temper tantrums.	☐	☐	☐	☐	☐	
16. Screams.	☐	☐	☐	☐	☐	
Behaviors commonly seen in placed children (children in care)						
17. Child will indiscriminately go with or to unfamiliar adults.	☐	☐	☐	☐	☐	
18. Child exhibits multiple fears, obsessions and worries.	☐	☐	☐	☐	☐	
19. Child appears to be comfortable in his/her isolation and aloneness. A sense of distance marks their relationships.	☐	☐	☐	☐	☐	

Mild: The behavior has a Slight effect and the behavior occurs only occasionally.
Moderate: The behavior has a Serious effect and the behavior occurs on a frequent basis.
Severe: The behavior has a Very Serious effect and the behavior occurs on a frequent basis.

Name _____

Social Security No.



Remember, mark only one box for each behavior.

Behaviors Behaviors commonly seen in placed children (children in care)	N/A	Mark if by History	Has behavior occurred within past year? If yes, mark severity.			Except where behavior is not applicable, give description of behavior.
			Mild	Moderate	Severe	
20. Child exhibits insatiable neediness (i.e. clinging behavior).	☐	☐	☐	☐	☐	
21. Child appears to be cooperative and submissive but usually does not follow through on actions or requests	☐	☐	☐	☐	☐	
22. Parentified child. Child acts older than his/her chronological age. Attempts to parent other children.	☐	☐	☐	☐	☐	
Mood and Anxiety Behaviors						
23. Appears sad, unhappy.	☐	☐	☐	☐	☐	
24. Has trouble sleeping.	☐	☐	☐	☐	☐	
25. Is fearful or anxious.	☐	☐	☐	☐	☐	
26. Stares blankly.	☐	☐	☐	☐	☐	
27. Expresses feeling worthless or inferior.	☐	☐	☐	☐	☐	
28. Withdraws, does not get involved with others.	☐	☐	☐	☐	☐	
29. Worries excessively, preoccupied with minor annoyances.	☐	☐	☐	☐	☐	
30. Complains of psychosomatic ailments.	☐	☐	☐	☐	☐	
31. Sudden mood changes.	☐	☐	☐	☐	☐	
32. Has stopped speaking.	☐	☐	☐	☐	☐	
Elimination Behaviors						
33. Wets on self during day.	☐	☐	☐	☐	☐	
34. Wets on bed at night.	☐	☐	☐	☐	☐	
35. Has bowel movements other than in toilet.	☐	☐	☐	☐	☐	
36. Smears or plays with bowel movements or urine	☐	☐	☐	☐	☐	
Thought Disorders						
37. Hallucinates.	☐	☐	☐	☐	☐	
38. Has delusions	☐	☐	☐	☐	☐	
39. Disorganized or incoherent speech.	☐	☐	☐	☐	☐	
40. Bizarre/Grossly Disorganized Behavior.	☐	☐	☐	☐	☐	

Mild: The behavior has a **Slight** effect and the behavior occurs only **occasionally**.
Moderate: The behavior has a **Serious** effect and the behavior occurs on a **frequent** basis.
Severe: The behavior has a **Very Serious** effect and the behavior occurs on a **frequent** basis.

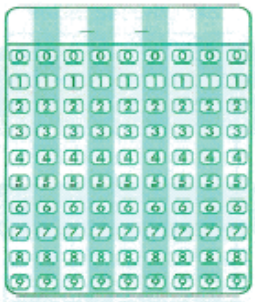
Remember, mark only one box for each behavior.

Behaviors Eating Disorders	N/A	Mark if by History	Has behavior occurred within past year? If yes, mark severity.			Except where behavior is not applicable, give description of behavior.
			Mild	Moderate	Severe	
41. Compulsive Overeating.	☐	☐	☐	☐	☐	
42. Anorexia-child refuses to maintain a minimally normal body weight.	☐	☐	☐	☐	☐	
43. Bulimia-child maintains normal body weight through binging and purging(through vomiting, laxatives, diuretics or enemas).	☐	☐	☐	☐	☐	
Sexual Behavior Problems						
44. Sexually promiscuous.	☐	☐	☐	☐	☐	
45. Prostitutes.	☐	☐	☐	☐	☐	
46. Sexually provocative.	☐	☐	☐	☐	☐	
47. Behaves like opposite sex.	☐	☐	☐	☐	☐	
48. Exhibits self in public.	☐	☐	☐	☐	☐	
49. Sexually peeks at others.	☐	☐	☐	☐	☐	
50. Masturbates in public.	☐	☐	☐	☐	☐	
51. Sexual play with peers.	☐	☐	☐	☐	☐	
52. Other sexual problems (such as touching others inappropriately).	☐	☐	☐	☐	☐	
Sexual Offending Behaviors						
53. Coerces other children into sexual acts.	☐	☐	☐	☐	☐	
54. Sexually molests other children.	☐	☐	☐	☐	☐	
55. Has exhibited sexual aggressiveness.	☐	☐	☐	☐	☐	
Danger to Self						
56. Verbal or physical suicidal threats.	☐	☐	☐	☐	☐	
57. Suicidal gestures or attempts.	☐	☐	☐	☐	☐	
58. Serious self abusive behavior.	☐	☐	☐	☐	☐	

Mild: The behavior has a **Slight** effect and the behavior occurs only **occasionally**.
Moderate: The behavior has a **Serious** effect and the behavior occurs on a **frequent** basis.
Severe: The behavior has a **Very Serious** effect and the behavior occurs on a **frequent** basis.

Name _____

Social Security No.



Remember, mark only one box for each behavior.

Behaviors Danger to Self	N/A	Mark if by History	Has behavior occurred within past year? If yes, mark severity. Mild	Moderate	Severe	Except where behavior is not applicable, give description of behavior.
59. Talks about suicide.	☐	☐	☐	☐	☐	
60. Places self in dangerous situations.	☐	☐	☐	☐	☐	
Danger to Others						
61. Exhibits life threatening aggression.	☐	☐	☐	☐	☐	
62. Physically aggressive behavior toward a child that results in any injury, potential injury, or intent to injure.	☐	☐	☐	☐	☐	
63. Physically aggressive behavior toward an adult that results in any injury, potential injury, or intent to injure.	☐	☐	☐	☐	☐	
64. Verbally threatens others.	☐	☐	☐	☐	☐	
65. Damages or destroys property.	☐	☐	☐	☐	☐	
66. Steals at home.	☐	☐	☐	☐	☐	
67. Steals outside the home.	☐	☐	☐	☐	☐	
68. Vandalizes.	☐	☐	☐	☐	☐	
69. Is cruel to animals.	☐	☐	☐	☐	☐	
70. Sets fires.	☐	☐	☐	☐	☐	
71. Carries weapons.	☐	☐	☐	☐	☐	
72. Ritualism.	☐	☐	☐	☐	☐	
73. Gang involvement.	☐	☐	☐	☐	☐	

Mild: The behavior has a **Slight** effect and the behavior occurs only **occasionally**.
Moderate: The behavior has a **Serious** effect and the behavior occurs on a **frequent** basis.
Severe: The behavior has a **Very Serious** effect and the behavior occurs on a **frequent** basis.

DHR
Level of Care

And

Specialized Foster Care

Application

Instructions and Attachments

April 2005

Completing the Application

The Level of Care system purchases placement services based upon a child's needs. There are six Levels of Care that cover the entire continuum of out-of-home care provided by the private sector, from basic Institutional Foster Care through Intensive Residential Treatment. The system needs in DFCS foster homes.

Please take the time to review the instructions carefully before completing the Level of Care application. The Level of Care checklist should assist you in making sure that you have aal the necessary documents.

The MPI-1 and attachments are submitted to the Provider Support Unit when funding is requested for Level of Care services and for Specialized Foster Care for a child. The MPI-1 and attachments are completed by the local agency case manager with input from the child's parent, foster or adoptive parent, and any other individuals who are familiar with the child's needs.

Completing the application and reviewing all of the materials should give you some sense of whether the child's needs fall between Levels One through Three, or Levels Four through Six. A final determination of the Level of Care or Specialized Foster Care needs of the child will be made by either the Provider Support Unit Policy Specialist or the Regional Social Services Treatment Specialist.

It is critical that you follow ALL of the instructions noted in the MPI-1 document. Failure to do so will result in a delay in processing the application for Level of Care or Specialized Foster Care services.

If you have any questions about the MPI-I instrument or any part of the process, please call your Provider Support Unit Policy Specialist or the Social Services Treatment Specialist in your region.

MPI-1 Instructions:

Questions 1-37

- Each item must be marked with the exception of items 17, 24, 28, 29, and 34. Those items require information that may not be applicable for a particular child. If they are applicable, please complete those items as well.
- For item #9, refer to the list of County Codes that are attached to the instructions.
- For item#36, refer to the ROLES Definitions, which are attached to the instructions.

Behavior Checklist

- The Behavior Checklist contains a list of 73 behaviors. For each behavior, mark that box that most closely describes how the behavior applies to the child. Mark only one box for each behavior.
- Any behavior marked **MUST** be described in the right column. Attach additional sheets if necessary.
- **Not Applicable:** Mark when the child has never displayed the behavior

- **By History:** If the behavior did **not** occur within the past year, but was a problem in the child's history, mark this item. Give a very brief description of the behavior.

- **Behavior within the Past Year:** Mark the severity of the behavior. Give a description of that behavior. Attach additional sheets if necessary.

    1. **Mild:** Mark **Mild** for the severity of the behavior if…

        - The behavior has occurred within the past year
        - The caseworker and the child's caretaker consider the behavior to have only a slight effect upon the child's daily functioning and his/her placement needs
        - The behavior has occurred only occasionally

    2. **Moderate:** Mark **Moderate** for the severity of the behavior if…

        - The behavior has occurred in the past year
        - The caseworker and the child's caretaker consider the behavior to have a serious effect upon the child's daily functioning and his/her placement needs
        - The behavior occurs on a frequent basis and/or poses a serious danger to self or others.

    3. **Severe:** mark **Severe** for the severity of the behavior if…

        - The behavior has occurred with the past year
        - The caseworker and the child's caretaker consider the behavior to have a **very serious** effect upon the child's daily functioning and his/her placement needs
        - The behavior occurs on a frequent basis and/or poses an intense danger to self or others

Submitting the Application Packet

If the child appears to have needs of a **Level One through Three**:
Submit the completed application packet (MPI-1 and Attachments) to the appropriate Provider Support Unit Regional Center.

If the child appears to have needs of a **Level Four through Six**:
Submit the completed application packet (MPI-1 and Attachments) to the Provider Support Unit, Two Peachtree Street, Suite 18-407, Atlanta, Georgia 30303-3142

If you are requesting a **Specialized Foster Care** per diem for a child in a DFCS foster home:
Submit the completed application packet (MPI-1 and Attachments) to the Provider Support Unit, Two Peachtree Street, Suite 18-407, Atlanta, Georgia 30303-3142

LOC-Caregiver Assessment Form (CAF)
(Completed by case manager and caregiver – if applicable)

Use this form for **Medically Fragile Children** only. Read all questions carefully and complete the categories that apply to the medically fragile child in your care and his/her condition. Use the following definition for medically fragile children to determine if the child meets medically fragile criteria.

Medically Fragile – A medically fragile child has at least one of the following:

- A condition that required dependence upon durable medical equipment (to include, but not limited to, a wheelchairs, walkers, etc….).
- A condition that requires dependence upon medical support equipment (to include, but not limited to , a respirator, feeding pump, suction machine, oxygen, etc….).
- A life-threatening, acute/chronic infectious disease, acute/chronic non-infectious disease requiring respiratory or other precautions (excluding normal childhood diseases).
- A terminal illness.
- A condition that requires ongoing administration of medication (intravenous or otherwise) or nutritional support.
- A condition that requires intensive rehabilitation and /or developmental disability services, or
- An inability to carryout activities of daily living as another child of the same age (to include, but not limited to, not attending school for more than a week because of a diagnosed medical condition, etc….).

For accuracy, please print legibly or type all information.

Date: _____

Child's Name: _____ Legal County:_____

Age:_____ Sex:_____ Weight:_____ Uses a wheelchair? _____Yes _____No

Social Security Number: _____ / _____ /_____

Eligibility Section

(Check only one) _____Initial _____IV-E _____IV-B (CW)

(Check all that apply) _____SSI _____ CS _____SSA _____Trust _____Personal
_____Other funds (What type?) _____

Medicaid Number:_____ Number activated? _____Yes _____ No

Specialized Foster Care (SFC) – Memorandum

To: _____ _____
Social Services Section Date

From: _____ _____
Contact Person County

_____ _____
Telephone Number Facsimile Number

Re: Specialized Foster Care (SFC) Funding Application

Type of Application (Check only one): _____ Initial Application $_____ Amount Requested
_____ Review $_____ Current Per Diem

$_____ Amount Requested

_____ _____
Name of Child Date of Birth

Designate the category that best describes the child's primary problem (check one):
_____ Medical
_____ Emotional / Behavioral

Case Reviewed by (check all that apply):
_____ An internal DFCS review team
_____ An interdisciplinary review committee
_____ Local MATCH

Date Reviewed: ____/____/____

The Reviewers concur, based on their professional judgment, that the child's condition is (check one):
_____ Mild
_____ Moderate
_____ Severe

The Reviewers concur, based on their professional judgment, that the child's placement continues to be appropriate and meet the needs of the child: _____ Yes _____ No
What is the Permanency Plan per the DFCS Case Plan? (Check one)
_____ Reunification _____ Adoption _____ Permanent Guardianship
_____ Long Term Foster Care _____ Emancipation _____ Kinship / Relative Care

If a child is 16 years or older,
1. Does he/she have a WTLP (Written Transitional Living Plan)? Check one: _____Yes _____ No
2. Is he/she participating in an Independent Living Program (ILP)? _____ Yes _____ No

Have the Parental Rights been terminated? (Check one) ____ Yes ____ No
If yes, please indicate the following:
1. Year terminated: _____
2. Has an adoptive home been identified? _____ Yes _____ No
3. Date of anticipated adoptive placement: _____

Adoption Assistance Requests:

You **MUST** attach documentation from the providers (i.e. physician, therapist, etc…) regarding the child's **prognosis** and **anticipated treatment and service needs.**

April 2005

Caregiver Checklist

(To be completed by case manager and caregiver)
Private Agency _____ Yes _____ No

_____
Name of Agency

_____ _____
Caregiver's Name Secondary Caregiver's Name, if applicable

How many months has the child been in the home of the caregiver? _____

Family Composition: (Give the name, age, *relationship of ALL household members*. Identify birth, adoptive, pre-adoptive and foster children. Indicate which, if any, children in the home are currently receiving SFC funds.) Attach a separate page if necessary.

Name	**Age**	**Relationship**	**SFC Funds (yes/no)**

Caregiver's Education: _____ Years of Experience as a foster parent: _____

Specialized Training to serve this child (include any certifications): _____
_____

Primary Caregiver's employment outside of the home: Company name _____ Hrs/week ____

During the last SFC eligibility period, if applicable, have there been any health and/or household changes experienced by the caregiver? Check one: _____ Yes _____ No
If yes, briefly describe. Include the effects the changes have had on the child. _____
_____

Briefly explain if the caregiver has changed during the last six months. _____
_____

1. Briefly describe the child's functioning in the following areas:
   a. Home _____
   _____

   b. School (include any changes in transportation, placement, etc…) _____
   _____

   c. Community _____
   _____

2. Briefly describe improvements the child has made since last review. _____

---

3. Briefly describe the factors that may have negatively impacted the child's functioning, if his/her condition has deteriorated since the last review. _____
_____

April 2005

4. Briefly describe the services provided to meet the child's needs. _____
_____

Briefly describe any additional services and/or treatment needs required by the child. _____
_____

Are treatment recommendations being followed by the caregiver? Check one. _____ Yes _____ No

Has the caregiver participated as a member of the treatment team since last review? ___ Yes ____ No

What is the number of counseling/therapy visits since the last review? _____

How many medical visits were made during the past six months? (i.e. emergency, regular, check-up, clinic visits, etc…) _____

Specify if the child has any new medical treatment needs. _____
_____

Briefly describe the child's prognosis. _____
_____

Services Provided to Meet the Child's Needs:

*** You must attach documentation from the providers ***

Type of Service	Provider	Frequency
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Signature Section: (This section must be signed by ALL parties. SFC application will not be accepted without appropriate signatures.)

_____ ___ _____
County Director / Designee Signature Date

_____ _____
Case manager's Supervisor Signature Date

_____ _____
Case Manager Signature Date

_____ _____
Caregiver's Signature Date

Specialized Foster Care (SFC) – Memorandum

SECTION I. FEEDING ISSUES

How long does it take to feed the child? _____
Is the child allergic to any foods? ____Yes ____No

If yes, what _____

Check which types of food child eats ____Puree ____Baby food ____Regular diet ____
Liquids only ____Diabetic foods Other_____

Has the child been diagnosed as Failure to Thrive? ____Yes ____No
List the medications prescribed for the child that are taken on a regular basis (add an additional page if needed)

MEDICATION	DOSE	FREQUENCY/TIMES PER DAY
_____	_____	_____
_____	_____	_____
_____	_____	_____

SECTION II. COMMUNICATION

1. Check all of the ways the child communicates ___Moves body ___moves head ___moves eyes ___gestures ___grunts ___makes sounds ___words ___sighs Other _____
2. Does the child require any visual aids? ____Yes ____No If yes, what? _____
3. Does the child make good eye contact with people?
4. Does the child wear a hearing aid?
5. Does the child have frequent ear infections?
6. Does the child understand more words than he/she can express?
7. Does the child cry for extended periods of time?
8. Does the child have an abnormal sleep pattern?
9. Does the child's mood appear to be sad or withdrawn? (eyes may appear dull)
10. Can the child put together words to form phrases and/or sentences?

SECTION III. EQUIPMENT

1. Check all of the equipment required by the child __wheelchair __walker __feeding tubes/type ___tracks ___oxygen ___ventilator ___respiratory machines ___braces ___prosthetics devises ___crutches ___colostomy
   Cast: ___full ____partial ____arm ____leg ____hp spica

2. Does the caregiver's home or auto require any special adoptive equipment for the child? (i.e. ramps, wide doors, bath rails, raised toilet seat, transfer benches, van lift, etc.)_____
   _____
   _____

3. Does the caregiver's home require additional electrical outlets, wiring, expenditure for medical equipment related directly to the care of this child (check one) ___Yes ____No

SECTION IV. INDEPENDENT FUNCTIONING (Completed if child is 4 years and older)

1. Check all of the following functions the child can perform: ___feed self ___wash hands ____clean teeth ___take bath/shower ___put on clothes ___use toilet ___zip clothes ___zip/unzip clothes ___helps with simple household tasks ___make simple lunch

2. Briefly describe the most independent thing the child can do._____
   _____

Level of Care and Specialized Foster Care
Application Checklist

I. Attachments Required in Level of Care Applications for Children with <u>Emotional/ Behavioral Needs:</u>

For all Levels:
___ MPI-1
___Comprehensive Child and Family Assessment
___Placement/Treatment History (Attachment 1)
___Current Social History (If CCFA is not current or not available)
___Psychological Evaluation (less than 2 yrs old)
___Psychiatric Evaluation, if available
___If child is in Special Education:
  ___IEP
  ___Eligibility Report
  ___School Psychological
___Discharge summaries from previous placements
___Copy of the current DFCS case plan
___Agreement regarding Application for Level of Care Services (Attachment 2A)

For Levels 4 through 6:

____Statement of Educational Services (Attachment 3)
____Written Statement from Community Mental Health staff detailing the services that have been provided, the length, the child and family response, the efforts to tailor services to the unique needs of the child and family, and any services the family has declined.
____If child is committed to DJJ:
  ____Current Commitment Order
  ____Screening Committee Placement Form
  ____Agreement regarding Application for Level of Care Services (Attachment 2A)
____If in Parental Custody:
  ____Parental Agreement (Attachment 2B)
  ____A detailed financial statement from the parents that includes all sources of income, including wages, child support, government benefits, etc….
  ____A statement from the parents' insurance company about the availability of mental health coverage and how much the company will cover for residential treatment

II. Attachments Required for Children Who are Medically Fragile

___Include items listed in Section i. For children under age 4, do not complete the MPI-1 Behavior Checklist unless it is applicable.
___Current statement (within the last 30 days) from the child's primary physician that includes: Diagnosis(es), Specific care needs, Ongoing needs, and Prognosis
___List of Equipment Needs
___Caregiver Assessment Form, if available (Attachment 4)
___Current Babies Can't Wait Service/Treatment plan, if applicable
___For a Child Leaving Hospital: Detailed Discharge Plan about what is required to care for child and optimize health

III. Attachments Required for Children with <u>Developmental Disabilities</u>

____Items listed in Section 1
____Items in Section II if the child is also Medically Fragile
____Adaptive Behavior Score
____Detailed Statement about what the Caregiver is doing or is expected to do to maximize the child's potential

IV. Attachments Required for Children with Special Needs in DFCS Foster Homes, i.e. <u>Specialized Foster Care</u>

____Items listed in Section I, II, and III (II and III only if applicable)
____Specialized Foster Care Memorandum (Attachment A)
____Medically Fragile Supplement (Attachment B)

DHR

B.J. Walker, Commissioner

Georgia Department of Human Resources • Division of Family and Children Services • Office of Child Protection
2 Peachtree Street, N.W • Suite 8-407 • Atlanta, GA 30303-3142 • Phone: 404-657-3550 • Fax: 404-657-9498

MEMORANDUM

TO: County Director
Rockdale County DFCS

FROM: Program Manager
Post Adoption Services
DFCS/OCP/Adoption Unit

RE: **Specialized Rate for Adoption Assistance**

DATE: October 21, 2005

The following child (ren) is/are approved for the special per diem (level of care) listed next to his/her name(s). The rate established for Adoption Assistance does not need to be re-evaluated once the determination has been made. Retain a copy of this memorandum in your Adoption Assistance record for audit purposes. If you have questions regarding this determination, please contact the Post Adoption Services Program Manager at (404) 463-3957.

NAME	AMOUNT
Susie Newman	**$20.00**

cc: Jane Raines

SENDING FORMS TO REVENUE MAXIMIZATION

A. Prior to adoptive placement (this should be completed for deferred applications also):

Form 223
Form 224
Form 227 (If placement date is known)
Copy of the initial court order removing the child from the home (only needs to contain the CTW language)

B. When the adoption is finalized: (At this point the child will begin receiving Medicaid under the adoption assistance program.)

Form 227 –to include the child's name following finalization and new social security number

At any other time there is a change, i.e. moving to a new residence, the MES shall be notified via form 227.

When moving out of state, Form 227 will notify the MES to terminate Medicaid. At this time, form 403 will be sent to the State Adoption Unit and a referral via ICAMA will be made for Medicaid coverage in the new state of residence.

GEORGIA DEPARTMENT OF HUMAN RESOURCES

Medicaid and IV-E Application for Foster Care and Adoption Assistance

This form is completed for each child entering foster care within five (5) working days of the child's placement.

Date 527 sent to Accounting: _____

Applicant Child's Name:_____ SSN: _____
DOB: _____ Gender: M F Race: _____ US Citizenship: Y N **Note: If not a U.S. Citizen, attach a copy of the INS documentation**
Child's Mother: _____ _____ SSN: _____ Race: DOB: _____
Address: _____ City, State, Zip: _____

Child's Father: _____ SSN: _____ Race: DOB: _____

Address: _____ City, State, Zip: _____ o Legal father o Putative Father

Parents are: o Married o Never Married o Separated o Divorced Has paternity been established? o Yes o No

Has child support been ordered in the juvenile court? ? o Yes o No If YES, attach a copy of the order for OCSE.

MEDICAID INFORMATION: County: _____ Removal Date: _____ Prior Months MAO? o Yes o No Month: _____

1. **Does this child receive any income directly? o Yes o No** Is income Supplemental Social Security Income (SSI)? o Yes o No
   If yes, indicate type, amount and frequency: _____ $ _____
   _____ $ _____
2. **Does this child have any resources?** o **Yes** o **No**
   If yes, indicate type and amount: _____ $ _____
   _____ $ _____
3. **Is the child pregnant? o Yes oNo Verified and documented? o Yes oNo Estimated Delivery Date: _____**
4. **Is the child covered by health insurance other than Medicaid?** o **Yes** o **No**
   If yes, name of insurance company: _____ Policy #: _____

   Name of insured: _____ Relationship to child: _____ Copy of card? o Yes o No

J JPPS/SSCM Signature _____ Date: _____

IV-E INFORMATION: **INITIAL COURT ORDER(S) FAXED: o YES o NO**

4a. List the name of the person with whom the child was living at removal: _____
e. Is this a ____parent ____specified relative*____other? If specified relative or other, list relationship :_____
f. In the court order, from whom is custody removed? _____
g. Is the person named in 4c the same person as in 4a? ____**Yes** _____**No** If no, did the child live with the person in 4c within the 6 months prior to removal from the home? ____**Yes** ____ **No** If yes, list the months: _____

*(For question 4b, specified relative is defined as a relative within the degree of relationship by 1996 AFDC policy)

List standard filing unit members in the removal home:

Name	DOB	Relationship to child	Gender	Race	SSN
_____	_____	_____	___	____	_____
_____	_____	_____	___	____	_____
_____	_____	_____	___	____	_____
_____	_____	_____	___	____	_____

5. **Parental Deprivation** (for AFDC Relatedness) Circle all that apply and parent(s) involved:

Absence	Death	Incarceration	Disability/Incapacity	Unemployed Parent
Mother Father	Mother Father	Mother Father	Mother Father	Mother Father

6. **Is the child placed in an approved foster care or child caring institution? o Yes o No**
   Name and address of current placement: _____
   Relationship: _____ _____
   _____
7. **Legal Information:** Date of Juvenile Court complaint/petition, VPA, or VS signature date: _____
   Physical/Constructive removal date: _____ Date of court hearing: _____
   a. Circle order type: court order or VPA or VS b. If VPA or VS, date of VPA/VS: _____
   c. Does initial court order contain "contrary to welfare/best interest" language**? o Yes o No**
   d. Was a court order that addresses "reasonable efforts to prevent removal" obtained within 60 days of child's removal? **(n/a to** Adoption Assistance) **: o YES o No** Date of court order or hearing: _____

JPPS/SSCM Signature: _____ Date: _____

Printed name of JPPS/SSCM: _____ Phone Number: ( ) _____

GEORGIA DEPARTMENT OF HUMAN RESOURCES

REMOVAL HOME INCOME AND ASSET CHECKLIST

Child's Name: _____ DOB: _____ Medicaid #: _____

Mother's Name: _____ Father's Name: _____

This information is for: o Application Month Month: _____ o Prior Month MAO Month: _____

INSTRUCTIONS: List the amounts of income and resources of the removal family by family member. Include any details known, such as employer, in the space provided. If there is no income or resources of a particular type, write n/a in the space provided. Attach additional sheets if more space is needed. **IF NO INCOME OR RESOURCES ARE REPORTED, HOUSEHOLD MANAGEMENT MUST BE ADDRESSED IN THE SECTION PROVIDED BELOW.**

Income Source	Gross Amt/Mo	Recipients	Description
Employment			Full or part-time work where a paycheck is received. Operation of a family day care in the family's home is considered self-employment. **Employer name, address, and phone number:** _____
Miscellaneous			Events of work where the work and pay do not occur on a regular basis. Example: Part-time work a few hours a week (amount of time varies)
Interest and Dividends			Interest paid on a savings or checking account, paid monthly. Dividends are payments made by a company to owners of the company's stock.
Child Support or Alimony			Any payments made by the parent(s) who is obligated to financially support a child or spouse. Court ordered child support? o Yes o No Attach copy of the order. If child support was ordered in another court of competent jurisdiction, specify the type of order and attach a copy. o OCSE order o Divorce order Issued in _____ County, State of _____
Adoption Assistance			Subsidies paid to parents adopting a child(ren) with special needs. Paid to whom? _____
Unemployment Benefit			Payment made weekly by the State to an unemployed worker who has been laid off or fired by their previous employer.
Worker's Compensation			Payment made by insurance companies on behalf of a company to a worker who has been injured/killed on the job and cannot work for a period of time.
Social Security Benefits			Federal funds paid monthly to persons age 62 or over or disabled, and their dependents. Social Security may be paid on behalf of a deceased family member.
Supplemental Security Income			SSI is a monthly payment to persons who are aged, blind, or disabled. NOTE: If SSI is received by the child, child is IV-E eligible at time of filing of adoption petition.
Veteran's Benefits			Monthly payments made to a person who served in the U.S. military. If veteran is disabled or deceased, a family member may receive the payment.
Military Allotments			A portion of a serviceman's/woman's pay set-aside for a family member, paid periodically.
TANF Benefits			Monthly benefits paid out by States to needy families (welfare)
Contributions			Any money received from friends and family.
Resources	**Dollar Value**	**Owner**	
Cash			Cash on hand.
Checking or Savings			Amounts held in checking and/or savings accounts. Include trust funds for children.
Money Loaned			Money owed to the household members from others.
Certificates of Deposit (CD'S)			Money deposited in a long-term savings plan with a specific maturity date for when the funds may be withdrawn.
Stocks and Bonds			Ownership of stock of a company, or bonds, company or public debt instruments that increase to a specified value
Other (define)			
Real Estate			List real estate holdings other than home residence. Address:
Vehicles			List any motor vehicle (ex: car, truck, motorcycle, boat or recreational vehicle) Make: _____ Model: _____ Year: ____ **Make: _____ Model: _____ Year: ___**

HOW IS THE HOUSEHOLD MANAGING WITHOUT INCOME AND/OR RESOURCES? _____

_____

Does anyone working pay for childcare or for the care of a disabled adult living in the home? **o Yes o No**

If yes, to whom is money paid? _____ Amount paid per mo: $_____

JPPS/SSCM Signature:_____ Date: _____

Printed name of SSCM/JPPS: _____ Phone number: ( ) _____

GEORGIA DEPARTMENT OF HUMAN RESOURCES

IV-E Eligibility Documentation Sheet

Check one:

Initial Decision: _____ Review: _____ Interim Change: _____ Child's Name: _____

IV-E Eligibility Month: _____ IV-E Eligible: _____YES _____ NO _____ IV-E /SSI only : _____

IV-E Reimbursable: _____ YES _____ NO Begin Date:_____ End Date (if applicable)_____

If not reimbursable, check all that apply: ____ IV-E Language ____ Custody ____ SSI ____ Age ____ Unapproved placement ____ Income/resources ____ Deprivation

Medicaid Eligibility: _____YES _____NO Class of Assistance _____

MES Signature: _____ Date: _____

Printed name of MES: _____ Phone Number: (_____) _____

Court Order Language:
Foster Care Placement:
Age:
Citizenship/Alienage:
Living with a Specified Relative & Removal Household:
Parental Deprivation:
Family Resources & Income (complete Form 239):
AFDC Relatedness Criteria Met?
Child's Income & Resources (complete IV-E budget):
Comments:

AU # _____ Medicaid # _____

Note: Court Order Language, Foster Care Placement, Age, Parental Deprivation & Child's Income/Resources ONLY must be completed at Review

GEORGIA DEPARTMENT OF HUMAN RESOURCES

NOTIFICATION OF CHANGE IN FOSTER CARE OR ADOPTION ASSISTANCE

Child: _____ Medicaid #: _____ Date: _____

Court Order Language "*Reasonable efforts to finalize"*	_____ Judicial determination was made on this date: _____ _____ Date of the court order with the required language is: _____ _____ Judicial determination was **NOT** made because: _____ It was omitted from the court order; _____ The court found that DFCS had **NOT** made "*reasonable efforts*"; _____ The finding was not timely; i.e., within 12 months
Foster Care Placement	_____ Child was placed in a fully approved/licensed facility effective: _____ Name/Address: _____ ____ Child moved to the above placement from another IV-E reimbursable home/facility? o No o Yes* * *To avoid two IV-E payments on the same day(s) of the child's move or concurrent placement, indicate in "Comments" the Name/Address of the prior home/facility and the date(s) of the IV-E payment.* _____ Child placed in a **NON** IV-E approved placement effective: _____ Name/Address: _____
Adoption Assistance	_____ Adoptive placement effective date: _____ _____ Adoption petition filing date: _____ _____ Adoption finalized as of date: _____
Parental Deprivation	_____ A change occurred in more or more of these "deprivation factors" in the removal home: o Absent parent returned o Parent deceased o Parent disabled/incapacitated o Parent unemployed o TPR/Surrender of parental rights Parent effected by this change: o Father o Mother Effective date: _____
Income/Resources (child's)	_____ There was a change in the child's income in the amount of $ _____ received from: o SSI o Child Support o VA Benefits o Social Security o Personal earnings o Other (specify): _____ _____ The child acquired resources total valued at : $ _____ Source(s): _____
Age	_____ This child reaches (or has reached) age 18 on (date): _____
Legal Responsibility	_____ Effective Date _____ DFCS no longer has legal responsibility for the child because: o Custody order expired o DFCS was relieved of custody o Other (explain): _____ _____ DFCS re-instated its expired order effective (date): _____
VPA	A judicial determination that continuation in foster care is in the "best interest" of the child: _____ Was obtained from the court within 180 days of placement _____ Was NOT obtained from the court within 180 days of placement. Effective date: _____
Trial Home Visit	The child's trial home visit exceeded 6 months or the time frame authorized by the court. Effective date: _____
Comments	

SSCM/JPPS signature: _____ CL#: _____ County: _____

SSCM/JPPS Printed Name: _____ Telephone No.: ( )_____

Form 227 (Rev. 10/05) Original – Services Record (Fax) Revenue Maximization Regional Office

GEORGIA DEPARTMENT OF HUMAN RESOURCES
ADOPTION ASSISTANCE MEMORANDUM

Form 403

DATE: _____

CHECK ONE

TO: **State Adoption Unit**
Adoption Assistance

FROM: _____
County Department of Family and Children Services

- ☐ State Agency Adoption (DHR child)
- ☐ Private Agency Adoption (DHR child)
- ☐ Relative Adoption (non DHR child)
- ☐ Private Agency Adoption (non DHR child)
- ☐ Relative Adoption (permanent custody to relative of child in DFCS temporary custody)

_____ Caseworker

_____ Telephone Number

RE: _____ Family Name _____ Father _____ Mother _____ Address

_____ Child's Birth Name _____ DOB _____ Race _____ Sex _____ FC Medicaid Number _____ Social Security Number

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

_____ Date of Finalization _____ New Medicaid Number _____ New Social Security Number

BENEFITS

This child has been approved for adoption assistance benefits. The approval is ___/___/___ through
Date

___/___/___.
18th birth month

The child is eligible for the following:
- ☐ State Funded 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)

STATUS CHANGE

- ☐ Child is 18 and in school full time. Benefits should continue (Must be verified every semester/quarter).
- ☐ Adoption Assistance should discontinue effective ___/___/___ Reason _____
- ☐ Medicaid Benefits should discontinue effective ___/___/___ Reason _____

Reasons:
Child over 18 and no longer in school full time
Child over 18 and has completed school
Child deceased
Adoptive parent(s) deceased
Verification of family's legal and financial responsibility cannot be established
Dissolution
Adoptive parent(s) failed to respond to renewal letter within thirty (30) days of receipt

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

BIRTH PARENTS

Mother's DOB _____ Father's DOB _____

☐ Mother Married at Time of Child's Birth

Mother's Rights Terminated _____ (Date) Father's Rights Terminated _____ (Date)

ADOPTIVE PARENT(S)

☐ Married Couple
☐ Single Female
☐ Single Male

Adoptive Mother's DOB _____ Adoptive Father's DOB _____

Adoptive Mother's Race _____ Adoptive Father's Race _____

Adoptive Parent Is:
☐ Stepparent
☐ Other Relative
☐ Foster Parent
☐ Non Relative

Child Placed From:
☐ Within State
☐ Another State
☐ Another Country

Child Placed By:
☐ Public Agency
☐ Private Agency
☐ Tribal Agency
☐ Independent Person
☐ Birth Parent

Adoption Finalized _____ (Date)

bbbbbbbbbb

COMPARING IVE FOSTER CARE AND IVE ADOPTION ASSISTANCE

Foster Care	Adoption Assistance
Child must reside in an approved foster care facility	Child may reside in a free home/no licensing necessary
IV-E eligibility is determined once (time of removal) and continues until child physically and legally leaves care or the child turns 18. Continuous reimbursability is contingent on several factors, i.e., court order renewal necessary every 12 months	IV-E eligibility is determined once (time of removal). IV-E eligibility at the time of removal means continuous reimbursability.
Court orders with contrary to the welfare language **and** reasonable efforts language	Court order with contrary to the welfare language
SSI eligible but not always IVE reimbursable	SSI eligible always IVE AA eligible
Child is in the custody of DHR	Child does not have to be in the temporary or permanent custody of DHR
Voluntarily surrendered child does not become IVE FC	VR with subsequent court order filed within 6 months of removal from AFDC eligible home. Court order must have CTW language

(Adoption Policy Manual Section 109.14 Title IVE AA-UAS Code 509)
(State Funded Adoption Assistance-UAS Code 508)

SCENARIOS

Working with a partner, identify which scenarios are or are not eligible for Title IVE Adoption Assistance.

Underline the correct choice IS or IS NOT in each scenario.

- If a child is eligible for AFDC during the month court proceedings removing the child from the home are initiated, or is eligible within six months prior to that time, the child **IS / IS NOT** potentially eligible for IVE Adoption Assistance. Remember: the initial removal court order must have the contrary to the welfare language.

- If a child enters care via a Voluntary Placement Agreement and the child was eligible for AFDC in the home, as long as a court order is obtained within 180 days of the Voluntary Placement Agreement being signed, the court order contains the contrary to the welfare language, at least one IVE foster care payment was made while the child was in placement when, the child **IS / IS NOT** eligible for Title IVE Adoption Assistance.

- If a child's parent was in foster care and receiving Title IVE funds that covered both the parent and the child when the adoption was initiated, the child **IS / IS NOT** eligible for Title IVE Adoption Assistance.

- If a child received IVE Adoption Assistance in a prior adoptive placement and that adoption dissolved or the parents are deceased, the child **IS / IS NOT** eligible for IVE Adoption Assistance in a subsequent adoption.

- If a child is a recipient of SSI or is eligible to receive SSI in the month the adoption petition is filed, the child **IS / IS NOT** eligible for IVE Adoption Assistance

TITLE IV-E ADOPTION ASSISTANCE CHART

IN EACH OF THE SITUATIONS BELOW, THE CHILD IS DETERMINED TO BE ELIGIBLE FOR IV-E AA IF THE ANSWER TO **EVERY** QUESTION IS YES FOR THE GIVEN SITUATION.

Children Receiving SSI	Is child receiving SSI or been determined eligible for SSI? Did the child remain IV-E eligible at the time of the filing of the adoption petition?
Children in Foster Care due to a Judicial Removal	Was the child removed from the home of a parent or specified relative? Was the removal a result of a judicial determination? (The judicial determination to be reviewed must be the **first** court ruling that sanctions the removal from the home)? Was the petition leading to the judicial determination filed within 6 months of the removal? Did the judicial determination removing the child from the home contain the "contrary to the welfare" language? At the time of removal was the child receiving or eligible to receive AFDC (or eligible for AFDC during the 6 months prior to the deprivation complaint or the petition leading to the removal being filed)?
Children in Foster Care via a Voluntary Placement Agreement (VPA)	Was child placed from the home pursuant to a VPA? Was an IV-E foster Care payment made while the VPA was in effect? At the time of signing of the VPA, was the child receiving or eligible to receive AFDC (or eligible to receive AFDC during the 6 months prior to VPA)? Was a judicial determination that contained the "contrary to the welfare" language made within 180 days of the VPA?
Children in Foster Care via a Voluntary Relinquishment	Was the child placed from the home pursuant to a Voluntary Relinquishment? At the time of the VR was the child receiving or eligible to receive AFDC (or eligible to receive AFDC during the 6 months prior to the VR)? Was a petition leading to a judicial determination to confirm the VR initiated within 6 months of the child living with the parent/specified relative? Did the judicial determination confirming the VR contain the "contrary to the welfare" language? Was the judicial determination case specific?
Children in Foster Care who are Adopted by a Specified Relative	Was the child removed from the home of a parent or specified relative? Was the removal a result of a judicial determination? At the time of removal was the child receiving or eligible to receive AFDC? Was the petition leading to the judicial determination initiated within 6 months of removal? Did the judicial determination removing the child from the home contain the "contrary to the welfare" language? Is the child being adopted by a specified relative (within 5th degree of relationship)?

Children Not in the Custody of DHR (Private Agency Placement)	Was the child placed from the home pursuant to a voluntary relinquishment to a private non-profit agency? At the time of the VR was the child receiving or eligible to receive AFDC (or eligible to receive AFDC at some point during the six months prior to the VR in the removal home? Was a petition leading to a judicial determination to confirm the voluntary relinquishment initiated within 6 months of the child living with the specified relative from whose home the removal occurred? Did the judicial determination confirming the VR contain the "contrary to the welfare" language? Was the judicial determination case specific?
Children Not in the Custody of DHR (Relative Adoption)	Was the child removed from the home of a parent or specified relative? Was the removal the result of judicial determination (may be a termination of parental rights)? At the time of removal was the child receiving or eligible to receive AFDC (or eligible to receive AFDC at some point during the 6 months prior to the petition leading to the removal being filed)? Was the petition leading to the judicial determination initiated within six months of removal? Did the judicial determination removing the child from the home contain the "contrary to the welfare" language? Is the child being adopted by a specified relative?
Child Not in the Custody of DHR but Received Title IV-E AA in a Prior Adoption	Does the child meet the definition of special needs? Is the child free for adoption? Have efforts been made to place the child without assistance?
Child Eligible as a Child of a Minor Parent and is Determined Special Needs	Is the child's parent in foster care and receiving Title IV-E foster care maintenance payments that cover the minor parent and the child at the time the adoption petition is initiated?

Adoption by a Specified Relative

Special Needs determination by the State Adoption Unit

Child must be eligible for AFDC in the removal home

Child has been removed from the home of the parent(s)/specified relative by virtue of a court order

Initial court order removing the child from the home contains the contrary to the welfare language

Petition leading to the removal from the home of the parent(s)/specified relative has been initiated within six months of the child living with the parent(s)/specified relative

- Important note: A child may or may not be in the custody of DHR to be eligible for IVE AA benefits under this category.

- If a child is in the temporary custody of DHR and the agency files a petition to terminate parental rights, if the plan is for a child to be adopted by a specified relative, the agency may ask the court to give permanent custody to the relative for the purpose of adoption. If the child meets Title IVE criteria, the child will be eligible for IVEAA benefits. In this situation, the agency does not have to complete a child life history on the child and the agency does not need to have an approved home study on the family. This scenario provides permanency very quickly for a qualified child.

ADOPTION ASSISTANCE BINGO

	FREE	

Module Four

Recurring/ Monthly Adoption Assistance

ASSESSING/NEGOTIATING THE ADOPTION ASSISTANCE AGREEMENT

What does assessment mean? An opinion on the nature, character, value and quality of something.

What does negotiation mean? To confer with another so as to come to terms or reach an agreement

All adoption assistance agreements must be assessed and negotiated with a prospective adoptive family.

- Must occur prior to placing a child on adoptive status.
- Although the amount of monthly benefits may not exceed the amount the child received in family foster care, the state agency and family must mutually agree on an amount the child will receive. It should not be assumed the child will be provided the maximum amount.
- The amount of income of the adopting parent does not make a child eligible or ineligible for adoption assistance, however the agency may consider the adopting family's capacity to incorporate the child into their household when negotiating this agreement.
- The family must be apprised of the agency policies regarding adoption assistance and must be made aware of the agency's role with the family once the adoption has finalized.

  - Remember: Adoption assistance is based on an amount that does not exceed a family foster care board rate. However, adoption assistance is for the special needs of the child. The maximum amount should not be given automatically. **Adoption Assistance is not a board rate.**

(Adoption Policy Manual Section 109.9)

ASSESSING/NEGOTIATING ADOPTION ASSISTANCE

***Things to remember**:*

- ✓ Agency philosophy
- ✓ Agency policy
- ✓ Needs of the child
- ✓ Provide information on the child, adoption assistance policy, post adoption services and community resources

Assessment/negotiation is an on-going process. By the time the child is placed on adoptive status, much of the information the family needs will have been provided to them. **Don't assume they know this information**. Knowledge is power and the prospective adoptive family needs to be empowered. This is critical particularly when there is more than one worker involved with the prospective adoptive parent and child.

- Remember: The amount of assistance must be mutually agreed upon; however, the agency cannot exceed the amount approved for the child as a family foster care board rate.

(Adoption Policy Manual Section 109.9)

Assessment/Negotiation Role Play #1

CASE MANAGER: *Mr. and Mrs. Smith, we are meeting today to discuss Timmy's adoptive placement, his special needs, the community resources and post adoption services that available to him, and to review his adoption assistance before we move forward and sign the adoptive placement agreement. The agency wants to make certain you have as much information about your child, his needs, and how we can assist you in making certain his placement is successful. You probably have some questions you need to ask us before we move forward, so this opportunity for us to meet makes it possible to do that.*

PROSPECTIVE ADOPTIVE PARENT: *I really don't think we need to spend too much time reviewing all this. Timmy has been in our home since he left the hospital. He is a healthy little boy, doesn't give us any problems, and we think we probably know more about him than you do.*

CASE MANAGER: *The importance of us reviewing all this is to make certain you are as well informed as possible. You know, it will be a big change from your role as a foster parent. I want to make certain you are aware of these changes. I want to make certain you are aware of the resources that are available to adopted children. I want to make certain you know our agency's policies and procedures regarding adoption assistance and post adoption services. We also need to mutually decide on an amount of monthly adoption assistance for Timmy.*

PROSPECTIVE ADOPTIVE PARENT: *What do you mean an amount? I thought Timmy was going to get the same amount that he received as a foster child in our home?*

CASE MANAGER: *Mr. and Mrs. Smith, the amount your child received as a foster child is not necessarily the same amount the child will receive as an adopted child. He is eligible to receive up to that amount, but that is something that we need to review. Ultimately the decision is yours, however, the agency requires an assessment and negotiation of all adoption assistance cases. With your permission, I would like to begin this process.*

PROSPECTIVE ADOPTIVE PARENT: *Okay. Let's get this over with.*

ASSESSMENT/NEGOTIATION ROLE PLAY #2

Prospective Adoptive Parent*: I will not be able to take care of Susie for less money than I have been paid by CCS. Why, once I adopt her, nobody will have to help me at all anymore and I will be stuck taking her to the doctor's visits, losing time from work, not receiving help with respite. The state just*

wants to dump her on me and then walk away. *Susie loves me and doesn't want to be with anyone else, but I just can't keep her for less money than I have been receiving.*

Case manager*: Ms. Iwanabe, why don't we look at what you feel is needed to care for Susie. We will need to consider the fact that the school will provide some services for her, Medicaid is available to provide some services, and there are many community resources and post adoption services that are available to her.*

Prospective Adoptive Parent*: The school doesn't want to do anything for my child. And what about respite? Sometimes I just need to get away and do things for myself. Gasoline costs a lot of money and on top of that, I will have to miss work to take her to her appointments. I don't see any way to support her and myself on less than $50 per day. Why, the state pays almost $200 a day to these private agencies. You can't tell me the money isn't there. And besides, maybe I just won't adopt Susie.*

Case manager*: Well, let's look at Susie's needs. I want you to tell me how much you think it will cost to provide for the services needed to meet these needs. I will write them down and we can see, perhaps more realistically, what it might cost to care for Susie. Keep in mind that we are not talking about supporting the family; we are talking about taking care of Susie's special needs.*

Ms. Iwanabe, we have reviewed Susie's needs. We have discussed the various community resources available to her, the services Medicaid will cover, and what the amount of adoption assistance will provide. We are not able to increase this approved amount. You will need to carefully consider your decision. We would like to have you proceed and become Susie's adoptive parent, however, if this is not possible, we will move towards recruiting another placement for her. Please think about this as this is a very important decision. We can schedule a time next Tuesday to either move forward with the adoptive placement or discuss plans for finding another permanent home for her. Susie is very attached to you. I hope you will be able to move forward and finalize this adoption.

COMPLETING THE ADOPTION ASSISTANCE PACKAGE

Once the negotiations with the family have occurred and the adoption assistance agreement has been signed, the case manager should maintain the following information in the adoption assistance record:

- Form 402

- Narrative: All narratives must identify the following: the child's special needs (as per state definition), efforts to place the child without adoption assistance (one part of the three prongs of special needs), the date the child became free for adoption (TPR or Surrender dates), age (date of birth), race, and social security number.

- Special Needs Memorandum

- Specialized Rate Memorandum (if applicable)

- Form 399

- Forms 223, 224, 225 and 227

- Initial Court Order (if applicable)

- SSI determination (if applicable)

- VPA (if applicable) and Verification of IVE FC Payment

- Copy of the Termination of Parental Rights Order or Voluntary Surrender

- If a child has been a recipient of IVE AA in a previous adoption, there must be verification of the receipt of IVE AA.

- Copy of Form 403

(Adoption Policy Manual Section 109.12)

DEFERRED ADOPTION ASSISTANCE AGREEMENTS

If a child is non-special needs at the time of adoptive placement, an application for adoption assistance benefits shall be completed and kept on file at the state Office of Adoption.

All deferred application packets must contain the same information as active adoption assistance agreement packages.

It is important that no money payment is identified at the time of the signing of this agreement Form 402 Part IIA and that Section IIB is circled indicating this is a deferred agreement.

The deferred AA package should contain verification of the child's foster care per diem for future reference. This may be a copy of Form 529.

The narrative for the deferred application package should list the background factors that the child has and should indicate the child is registered in the state exchange, adopted by a specified relative or foster parent or that the family is unable to adopt the child without adoption assistance benefits if the child should exhibit special needs at a later point in time.

If the child is determined special needs at a later point in time, a new narrative identifying the special needs of the child and a Form 402 shall be completed.

(Adoption policy manual 109.4)

Georgia Department of Human Resources

ADOPTION ASSISTANCE AGREEMENT

The following agreement has been entered into by and between:

_____

State Agency/Other Relevant Agencies

_____ _____/_____

Address Telephone Number

hereafter called the "agency(ies)" and

_____

Adoptive Parent(s)' Full Name(s)

_____ _____/_____

Address Telephone Number

hereafter called the "adoptive parent(s)"

---

for the purpose if facilitating the legal adoption of _____

(Child's First Name)

born on _____ and to aid the adoptive family in providing proper care for this child.

(Date of Birth)

This document is the Initial Agreement:

The prospective adoptive parent(s) agree that he / she / they intend to adopt _____

(Child's First Name)

and have signed this document prior to finalization of the adoption for the purpose of receiving Adoption Assistance payments and/or services for the child under **(Title IV-E)** or **(State Adoption Assistance), (Non-Recurring Adoption Expenses), (Medicaid).**

_____ was placed on _____

(Child's First Name) (33/37 Date)

The Approval Period is From _____ To _____

A renewal notice shall be sent sixty (60) days prior to a year from the original one-year anniversary of signing this Agreement. Renewal notices shall be sent annually.

PROVISIONS OF AGREEMENT

I. DEFINITIONS

A. **Family Foster Care Board Rate/Specialized Family Foster Care Board Rate**-The per diem rate approved for a child placed in a DFCS family foster home.

B. **Adoptive Placement**-The placement of a child who is free for adoption following the signing of the Adoption Placement Agreement (Form 33 or 37).

C. **Special Needs**- Any child eight (8) years of age or over; any child of African American heritage one (1) year of age or over; members of a sibling group of three (3) or more to be placed together; members of a sibling group of two (2) to be placed together where one is age eight (8) or over or has another special need as defined herein; any child with documented physical, emotional, or mental problems or limitations, or a predisposition there of.

II. ASSISTANCE

A. Monthly Cash Payment:

☐ Yes $ _____ ☐ No

1. The amount of this monthly cash payment (Adoption Assistance) is based on the needs of the child and the circumstances of the adoptive parents, and has been determined by mutual agreement between the adoptive parents and the county department.

2. The amount of the Adoption Assistance payment may not exceed the DFCS Family Foster Care Board Rate or Specialized DFCS Family Foster Care Board Rate approved for the child prior to the adoptive placement (Exception: cost of living or age level increases for Adoption Assistance as authorized by DHR).

3. If the monthly Adoption Assistance payment designated on this Agreement exceeds the DFCS Family Foster Care Board Rate or Specialized Family Foster Care Board Rate, the monthly payment will be adjusted to reflect the applicable DFCS Family Foster Care Board Rate or Specialized Family Foster Care Board Rate. The adoptive parent(s) shall be given written notice of any adjustments to their monthly payment made pursuant to this paragraph. The adjustment will take effect in the month immediately following the month the adoptive parents receive notice of the adjustment.

4. The adoptive parent(s) will reimburse any overpayments of Adoption Assistance made by the county department.

5. Adjustments in cash Adoption Assistance payments may be made with the concurrence of the adoptive parent(s), excluding adjustments made under paragraph A3, based upon changes in the needs of the child, changes in circumstance of the adoptive family, or changes in the maximum allowable Adoption Assistance payment. Documentation of changes in the child's needs or the family's circumstances may be required.

6. If the child in this Agreement is placed in foster care or a residential facility at state expense, the adoptive parent(s) may continue to receive Adoption Assistance payments if the permanency plan is reunification and the family's on-going financial responsibility for the child can be established. For the child placed in a residential facility, the adoptive parent(s) will be asked to contribute to the child's out of home expenses. If financial responsibility cannot be verified, Adoption Assistance will discontinue until the child returns home.

7. If a child is no longer in the home and the family fails to report this change in the child's placement and continues to receive Adoption Assistance payments, the family will be responsible for reimbursing the overpayment to the county department. If the child returns to the adoptive home at a later time, Adoption Assistance benefits may not be reinstated until the overpayment is completed.

B. This is a deferred application only. No money payment is approved at this time. Documentation of special needs related to background factors must be presented in making a decision regarding eligibility for Adoption Assistance benefits **(Payments shall commence at the time of receipt of documentation and determination of special needs eligibility by the State Adoption Unit.)**

C. Non-recurring Adoption Assistance (Must attach original receipts. Payments are provided only after the finalization of the adoption).

D. Medical Care

1. Medical Benefits as provided under Title XIX of the Social Security Act (Medicaid) will be available to this child in accordance with the procedures of the state in which this child resides.

2. Procedures for meeting the cost of medical care, including consideration of the family's health insurance are to be identified as follows:

This child	☐ will	☐ will not	be covered by the family's health insurance.
This child	☐ will	☐ will not	be covered by Medicaid.
This child	☐ will	☐ will not	be covered by military medical benefits.

E. Social Services

1. Social Services as provided under Title XX of the Social Security Act will be provided to this child in accordance with the procedures of the state in which he/she resides.

2. Title XX services are available to Title IV-E Adoption Assistance recipients in their state of residence.

F. When moving to another state the family should notify the _____ County Department of Family and Children Services of their relocation. The family needs to indicate when they will be moving and provide the county department with their new address. _____ County will continue to provide Adoption Assistance payments. Georgia is a member of the Interstate Compact on Adoption and Medical Assistance. The procedures of the Compact are to be followed.

III. NOTIFICATION OF CHANGE

A. The Adoptive parent(s) shall notify the county department of changes in address.

B. The adoptive parent(s) shall immediately notify the county department if the child is no longer attending school on a fulltime basis after age 18.

C. The adoptive parent(s) shall immediately notify the county department if the child is no longer in the home.

D. The adoptive parent(s) shall immediately notify the county department, in writing, if they are no longer legally or financially responsible for the support of the child.

E. The county department shall notify the adoptive parent(s) of changes in Adoption Assistance payments resulting from increases or decreases authorized by DHR.

F. The county department shall notify the adoptive parent(s) of discontinuation of benefits if the family's financial or legal responsibility for the child in this Agreement cannot be established.

IV. RENEWAL AGREEMENT

A. The renewal agreement serves as verification that the adoptive parent(s) remain(s) legally and financially responsible for the adoptive child.

B. This agreement is renewed annually by the adoptive parent(s) and the county department.

C. The county department shall notify the adoptive parent(s), in writing, sixty (60) days before the need for renewal and shall provide the adoptive parent(s) with the appropriate forms.

D. The adoptive parent(s) shall respond to the renewal letter within thirty (30) days of receipt. Annual verification is needed for the continuation of Medicaid eligibility.

V. TERMINATION

Termination will occur in any of the following circumstances:

A. This Agreement shall terminate upon the conclusion of the terms of this Agreement.

B. This Agreement shall terminate upon the request of the adoptive parent(s).

C. Adoption Assistance payments shall terminate when the child reaches the age of 18. Adoption Assistance may be provided at *State Option* if the child is attending high school on a full time basis and remains in need of assistance. Benefits terminate when high school is completed or the child turns 21, whichever comes first. Any child placed for adoption at age 13 or older may continue to receive benefits until age 21 if attending high school, technical school, or college on a full time basis. Documentation from the school is required on a quarterly or semester basis. Only children who had been in the permanent custody of DHR are eligible for benefits after age 18.

D. This Agreement shall terminate upon the child's death.

E. This Agreement shall terminate upon the death of the adoptive parent(s) of the child (one in a single parent family and both in a two-parent family).

F. This Agreement shall terminate at the cessation of legal responsibility of the adoptive parent(s) for the child.

G. If the adoptive parent(s) fail to participate in the renewal process, monthly Adoption Assistance benefits will be held until the renewal form is completed and returned to the county department. An annual renewal is necessary for the continuation of Medicaid benefits

VI. APPEAL

Adoptive parent(s) may appeal the county department's decision to reduce, change or terminate Adoption Assistance in accordance with the rules and procedures of the state's fair hearing and appeal process, except where the change was made pursuant to paragraph II (A)(3).

Application for appeal should be made to the County Department of Family and Children Services.

This Agreement shall remain in effect regardless of the State of which the adoptive parent(s) is a resident.

This Agreement will expire on the child's 18th birthday or as outlined in IVC, subject to annual renewal, unless termination occurs as a result of one or more of the conditions set forth in Section IV, Termination.

******

Adoptive Mother's Signature	Date
Adoptive Father's Signature	Date
Authorized Agency Representative's Signature / Title	Date
County Director / Designee's Signature	Date
A signed copy of the Adoption Assistance Agreement given/sent to the adoptive parent(s) on	Date

NOTE: **Attachments to Be Included in the Adoption Assistance Record:**

- **Narrative addressing special needs and efforts to place child without Adoption Assistance**
- **Special needs determination**
- **Specialized DFCS Family Foster Care based Adoption Assistance determination (if applicable)**
- **For IV-E child, date or removal from the specified relative; the initial court order; requests for and verification of IV-E eligibility from Revenue Maximization at the time removal (Forms 223, 224, and 225).**
- **Form 399**
- **Form 403**

EXAMPLE OF AN ADOPTION ASSISTANCE NARRATIVE

Olivia Jones d.o.b. 02/26/02
S.S. # 123-45-6789

Olivia Jones is a special needs child based on her age (three years) and race (African American).

Olivia is being adopted by her foster mother with whom she has lived for the past eight months. She is registered in the state adoption exchange.

Olivia entered care due to abandonment. Her parental rights were terminated in July 2005.

DHR

B.J. Walker, Commissioner

Georgia Department of Human Resources • Division of Family and Children Services • Adoption Unit
2 Peachtree Street, N.W • Suite 8-400 • Atlanta, GA 30303-3142 • Phone: 404-657-3550 • Fax: 404-657-9498

MEMORANDUM

TO: County Director
Terrell County DFCS

FROM: Adrian J. Owens
Policy Specialist
Post Adoption Services

RE: Olivia Jones **DOB: 2/26/2002**

DATE: December 29, 2005

This child (is) (is not) registered as a child with special needs for the purpose of Adoption Assistance based on age.

If this child has background factors only, have the family sign a deferred Adoption Assistance Agreement to be kept on file. Please inform the family that future consideration for Adoption Assistance will be determined by the State Adoption Unit.

cc: Adrian Owens

(Manual Reference: 109.3)

MEMORANDUM

TO: County Director
Rockdale County DFCS

FROM: Program Manager
Post Adoption Services
DFCS/OCP/Adoption Unit

RE: **Specialized Rate For Adoption Assistance**

DATE: October 21, 2005

The following child(ren) is/are approved for the special per diem (level of care) listed next to his/her name(s). The rate established for Adoption Assistance does not need to be re-evaluated once the determination has been made. Retain a copy of this memorandum in your Adoption Assistance record for audit purposes. If you have questions regarding this determination, please contact the Post Adoption Services Program Manager at (404) 463-3957.

NAME	AMOUNT
Susie Newman	**$20.00**

cc: Jane Raines

Georgia Department of Human Resources

Verification of Receipt of Information Packet Regarding Post Adoption Services/Adoption Assistance Benefits

This is to confirm that (we) (I) have received a packet of information regarding the Post Adoption Services and the Adoption Assistance Program provided by the DFCS State Adoption Unit and the

_____ County Department of Family and Children Services.

We (I) received this packet of information at the following time: (Please check appropriate box)

- ☐ IMPACT
- ☐ Signing of Form 150
- ☐ Signing of the Form 33/37

We (I) understand that we may request this information at another time if needed. We (I) understand that current information regarding benefits can be located on the Internet at www.gaadoptionresources.org.

_____	_____
Parent Signature	Date
_____	_____
Parent Signature	Date
_____	_____
Agency Representative Signature	Date

A copy of this form shall be given to the prospective adoptive parent(s); one copy will be retained in the Adoption Assistance record; and one copy will be sent to the State Adoption Unit at the time the Form 33/37 is signed.

GEORGIA DEPARTMENT OF HUMAN RESOURCES

Form 223

Medicaid and IV-E Application for Foster Care and Adoption Assistance

This form is completed for each child entering foster care within five (5) working days of the child's placement.

Date 527 sent to Accounting: _____

Applicant Child's Name:_____ SSN: _____

DOB: _____ Gender: M F Race: _____ US Citizenship: Y N **Note: If not a U.S. Citizen, attach a copy of the INS documentation**

Child's Mother: _____ _____ SSN: _____ Race: DOB: _____

Address: _____ City, State, Zip: _____

Child's Father: _____ SSN: _____ Race: DOB: _____

Address: _____ City, State, Zip: _____ o Legal father o Putative Father

Parents are: o Married o Never Married o Separated o Divorced Has paternity been established? o Yes o No

Has child support been ordered in the juvenile court? ? o Yes o No If YES, attach a copy of the order for OCSE.

MEDICAID INFORMATION: County: _____ Removal Date: _____ Prior Months MAO? o Yes o No Month: _____

1. **Does this child receive any income directly? o Yes o No** Is income Supplemental Social Security Income (SSI)? o Yes o No
   If yes, indicate type, amount and frequency: _____ $ _____
   _____ $ _____
2. **Does this child have any resources?** o **Yes** o **No**
   If yes, indicate type and amount: _____ $ _____
   _____ $ _____
3. **Is the child pregnant? o Yes oNo Verified and documented? o Yes oNo Estimated Delivery Date: _____**
4. **Is the child covered by health insurance other than Medicaid?** o **Yes** o **No**
   If yes, name of insurance company: _____ Policy #: _____

   Name of insured: _____ Relationship to child: _____ Copy of card? o Yes o No

JPPS/SSCM Signature _____ Date: _____

IV-E INFORMATION: **INITIAL COURT ORDER(S) FAXED: o YES o NO**

4a. List the name of the person with whom the child was living at removal: _____

b. Is this a ____parent ____specified relative*____other? If specified relative or other, list relationship :_____

c. In the court order, from whom is custody removed? _____

d. Is the person named in 4c the same person as in 4a? ____**Yes** _____**No** If no, did the child live with the person in 4c within the 6 months prior to removal from the home? ____**Yes** ____ **No** If yes, list the months: _____

*(For question 4b, specified relative is defined as a relative within the degree of relationship by 1996 AFDC policy)

List standard filing unit members in the removal home:

Name	DOB	Relationship to child	Gender	Race	SSN
_____	_____	_____	___	____	_____
_____	_____	_____	___	____	_____
_____	_____	_____	___	____	_____
_____	_____	_____	___	____	_____

5. **Parental Deprivation** (for AFDC Relatedness) Circle all that apply and parent(s) involved:

Absence	Death	Incarceration	Disability/Incapacity	Unemployed Parent
Mother Father	Mother Father	Mother Father	Mother Father	Mother Father

6. **Is the child placed in an approved foster care or child caring institution? o Yes o No**
   Name and address of current placement: _____
   Relationship: _____ _____
   _____

7. **Legal Information:** Date of Juvenile Court complaint/petition, VPA, or VS signature date: _____
   Physical/Constructive removal date: _____ Date of court hearing: _____
   a. Circle order type: court order or VPA or VS b. If VPA or VS, date of VPA/VS: _____
   c. Does initial court order contain "contrary to welfare/best interest" language**? o Yes o No**
   d. Was a court order that addresses "reasonable efforts to prevent removal" obtained within 60 days of child's removal? **(n/a to** Adoption Assistance) **: o YES o No** Date of court order or hearing: _____

JPPS/SSCM Signature: _____ Date: _____

Printed name of JPPS/SSCM: _____ Phone Number: ( ) _____

Form 224

GEORGIA DEPARTMENT OF HUMAN RESOURCES
REMOVAL HOME INCOME AND ASSET CHECKLIST

Child's Name: _____ **DOB:** _____ **Medicaid #:** _____

Mother's Name: _____ **Father's Name:** _____

This information is for: o **Application Month Month:** _____ o **Prior Month MAO Month:** _____

INSTRUCTIONS: List the amounts of income and resources of the removal family by family member. Include any details known, such as employer, in the space provided. If there is no income or resources of a particular type, write n/a in the space provided. Attach additional sheets if more space is needed. **IF NO INCOME OR RESOURCES ARE REPORTED, HOUSEHOLD MANAGEMENT MUST BE ADDRESSED IN THE SECTION PROVIDED BELOW.**

Income Source	Gross Amt/Mo	Recipients	Description
Employment			Full or part-time work where a paycheck is received. Operation of a family day care in the family's home is considered self-employment. **Employer name, address, and phone number:** _____
Miscellaneous			Events of work where the work and pay do not occur on a regular basis. Example: Part-time work a few hours a week (amount of time varies)
Interest and Dividends			Interest paid on a savings or checking account, paid monthly. Dividends are payments made by a company to owners of the company's stock.
Child Support or Alimony			Any payments made by the parent(s) who is obligated to financially support a child or spouse. Court ordered child support? o Yes o No Attach copy of the order. If child support was ordered in another court of competent jurisdiction, specify the type of order and attach a copy. o OCSE order o Divorce order Issued in _____ County, State of _____
Adoption Assistance			Subsidies paid to parents adopting a child(ren) with special needs. Paid to whom? _____
Unemployment Benefit			Payment made weekly by the State to an unemployed worker who has been laid off or fired by their previous employer.
Worker's Compensation			Payment made by insurance companies on behalf of a company to a worker who has been injured/killed on the job and cannot work for a period of time.
Social Security Benefits			Federal funds paid monthly to persons age 62 or over or disabled, and their dependents. Social Security may be paid on behalf of a deceased family member.
Supplemental Security Income			SSI is a monthly payment to persons who are aged, blind, or disabled. NOTE: If SSI is received by the child, child is IV-E eligible at time of filing of adoption petition.
Veteran's Benefits			Monthly payments made to a person who served in the U.S. military. If veteran is disabled or deceased, a family member may receive the payment.
Military Allotments			A portion of a serviceman's/woman's pay set-aside for a family member, paid periodically.
TANF Benefits			Monthly benefits paid out by States to needy families (welfare)
Contributions			Any money received from friends and family.
Resources	**Dollar Value**	**Owner**	
Cash			Cash on hand.
Checking or Savings			Amounts held in checking and/or savings accounts. Include trust funds for children.
Money Loaned			Money owed to the household members from others.
Certificates of Deposit (CD'S)			Money deposited in a long-term savings plan with a specific maturity date for when the funds may be withdrawn.
Stocks and Bonds			Ownership of stock of a company, or bonds, company or public debt instruments that increase to a specified value
Other (define)			
Real Estate			List real estate holdings other than home residence. Address:
Vehicles			List any motor vehicle (ex: car, truck, motorcycle, boat or recreational vehicle) ***Make:*** _____ ***Model:*** _____ ***Year:*** _____ **Make:** _____ **Model:** _____ **Year:** _____

HOW IS THE HOUSEHOLD MANAGING WITHOUT INCOME AND/OR RESOURCES? _____

Does anyone working pay for childcare or for the care of a disabled adult living in the home? **o Yes o No**
If yes, to whom is money paid? _____ Amount paid per mo: $_____

JPPS/SSCM Signature: _____ Date: _____

Printed name of SSCM/JPPS: _____ Phone number: ( ) _____

GEORGIA DEPARTMENT OF HUMAN RESOURCES

Form 225

IV-E Eligibility Documentation Sheet

Check one:

IV-E Eligibility Month: _____ IV-E Eligible: _____YES _____ NO _____ IV-E /SSI only : _____
IV-E Reimbursable: _____ YES _____ NO Begin Date:_____ End Date (if applicable)_____
If not reimbursable, check all that apply: ____ IV-E Language ____ Custody ____ SSI ____ Age ____ Unapproved placement ____ Income/resources ____ Deprivation
Medicaid Eligibility: _____YES _____NO Class of Assistance _____
MES Signature: _____ Date: _____
Printed name of MES: _____ Phone Number: ( ) _____

Court Order Language:
Foster Care Placement:
Age:
Citizenship/Alienage:
Living with a Specified Relative & Removal Household:
Parental Deprivation:
Family Resources & Income (complete Form 239):
AFDC Relatedness Criteria Met?
Child's Income & Resources (complete IV-E budget):
Comments:

Initial Decision: _____ Review: _____ Interim Change: _____ Child's Name: _____
AU # _____ Medicaid # _____

Note: Court Order Language, Foster Care Placement, Age, Parental Deprivation & Child's Income/Resources ONLY must be completed at Review

GEORGIA DEPARTMENT OF HUMAN RESOURCES

NOTIFICATION OF CHANGE IN FOSTER CARE OR ADOPTION ASSISTANCE

Child: _____ **Medicaid #:** _____ **Date:** _____

Court Order Language "*Reasonable efforts to finalize"*	_____ Judicial determination was made on this date: _____ _____ Date of the court order with the required language is: _____ _____ Judicial determination was **NOT** made because: _____ It was omitted from the court order; _____ The court found that DFCS had **NOT** made "*reasonable efforts*"; _____ The finding was not timely; i.e., within 12 months
Foster Care Placement	_____ Child was placed in a fully approved/licensed facility effective: _____ Name/Address: _____ _____ Child moved to the above placement from another IV-E reimbursable home/facility? o No o Yes* * *To avoid two IV-E payments on the same day(s) of the child's move or concurrent placement, indicate in "Comments" the Name/Address of the prior home/facility and the date(s) of the IV-E payment.* _____ Child placed in a **NON** IV-E approved placement effective: _____ Name/Address: _____
Adoption Assistance	_____ Adoptive placement effective date: _____ _____ Adoption petition filing date: _____ _____ Adoption finalized as of date: _____
Parental Deprivation	_____ A change occurred in more or more of these "deprivation factors" in the removal home: o Absent parent returned o Parent deceased o Parent disabled/incapacitated o Parent unemployed o TPR/Surrender of parental rights Parent effected by this change: o Father o Mother Effective date: _____
Income/Resources (child's)	_____ There was a change in the child's income in the amount of $ _____ received from: o SSI o Child Support o VA Benefits o Social Security o Personal earnings o Other (specify): _____ _____ The child acquired resources total valued at : $ _____ Source(s): _____
Age	_____ This child reaches (or has reached) age 18 on (date): _____
Legal Responsibility	_____ Effective Date _____ DFCS no longer has legal responsibility for the child because: o Custody order expired o DFCS was relieved of custody o Other (explain): _____ _____ DFCS re-instated its expired order effective (date): _____
VPA	A judicial determination that continuation in foster care is in the "best interest" of the child: _____ Was obtained from the court within 180 days of placement _____ Was NOT obtained from the court within 180 days of placement. Effective date: _____
Trial Home Visit	The child's trial home visit exceeded 6 months or the time frame authorized by the court. Effective date: _____
Comments	

SSCM/JPPS signature: _____ **CL#:** _____ **County:** _____
SSCM/JPPS Printed Name: _____ **Telephone No.: ( )**_____
Form 227 (Rev. 10/05) Original – Services Record (Fax) Revenue Maximization Regional Office

GEORGIA DEPARTMENT OF HUMAN RESOURCES
ADOPTION ASSISTANCE MEMORANDUM

Form 403

DATE: _____

CHECK ONE

TO: **State Adoption Unit**
Adoption Assistance

FROM: _____
County Department of Family and Children Services

- ☐ State Agency Adoption (DHR child)
- ☐ Private Agency Adoption (DHR child)
- ☐ Relative Adoption (non DHR child)
- ☐ Private Agency Adoption (non DHR child)
- ☐ Relative Adoption (permanent custody to relative of child in DFCS temporary custody)

_____ Caseworker

_____ Telephone Number

RE: _____ Family Name _____ Father _____ Mother _____ Address

_____ Child's Birth Name _____ DOB _____ Race _____ Sex _____ FC Medicaid Number _____ Social Security Number

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

_____ Date of Finalization _____ New Medicaid Number _____ New Social Security Number

BENEFITS

This child has been approved for adoption assistance benefits. The approval is ___/___/___ through Date

___/___/___. 18th birth month

The child is eligible for the following:

- ☐ State Funded 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)

STATUS CHANGE

☐ Family has moved to _____ (Address) If moving out of state, attach 402 with referral Effective ___/___/___ Date

- ☐ Child is 18 and in school full time. Benefits should continue (Must be verified every semester/quarter).
- ☐ Adoption Assistance should discontinue effective ___/___/___ Reason _____
- ☐ Medicaid Benefits should discontinue effective ___/___/___ Reason _____

Reasons:

Child over 18 and no longer in school full time
Child over 18 and has completed school
Child deceased
Adoptive parent(s) deceased
Verification of family's legal and financial responsibility cannot be established
Dissolution
Adoptive parent(s) failed to respond to renewal letter within thirty (30) days of receipt

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

BIRTH PARENTS

Mother's DOB _____ Father's DOB _____

☐ Mother Married at Time of Child's Birth

Mother's Rights Terminated _____ Father's Rights Terminated _____
(Date)

(Date)

ADOPTIVE PARENT(S)

☐ Married Couple
☐ Single Female
☐ Single Male

Adoptive Mother's DOB _____ Adoptive Father's DOB _____

Adoptive Mother's Race _____ Adoptive Father's Race _____

Adoptive Parent Is:
☐ Stepparent
☐ Other Relative
☐ Foster Parent
☐ Non Relative

Child Placed From:
☐ Within State
☐ Another State
☐ Another Country

Child Placed By:
☐ Public Agency
☐ Private Agency
☐ Tribal Agency
☐ Independent Person
☐ Birth Parent
Adoption Finalized _____
(Date)

Module Five

Additional Benefits and Their Duration

MEDICAID

Who is eligible?: The majority of children who are eligible to receive monthly adoption assistance benefits are eligible to receive Medicaid. The exceptions to this would be children who are ineligible due to legal status or income.

How to apply: Submit form 227 and Form 403 to the Revenue Maximization Unit when the adoption has been finalized. The child's name as it should appear on the Medicaid card and the child's new social security should be included.

Once form 225 has been received from the Revenue Maximization Unit, submit form 403 with the name change, new social security number and new Medicaid number to the State Adoption Unit.

Family relocation in Georgia: To transfer from one county to another in-state the Revenue Maximization Unit will need to be notified via Form 227. Notify the State Adoption Unit via Form 403.

Moving to another state: If a child moves to a new state, the SSCM will notify the Revenue Maximization Unit to terminate Medicaid via form 227. The SSCM will send a copy of Form 403 with the new address to the State Adoption Unit.

All changes will be reported to the Revenue Maximization Unit via Form 227.

All IVE cases will become state funded once the child turns age 18, if the child continues to be eligible for adoption assistance benefits. Rev Max receives Form 227 and the State Adoption Unit receives Form 403.

(Adoption Policy Manual Sections 109.23 and 109.26)

NON-RECURRING ADOPTION EXPENSES

Who is eligible? Any special needs child who is being adopted with the exception of one being adopted by a birth parent or step-parent.

When may these expenses be paid? Non-recurring adoption assistance benefits are payable only after the adoption has been finalized.

What expenses are covered? Any of the expenses that relate to the finalization of the adoption, i.e. attorney fees, court costs, transportation expenses for pre-placement visitation, costs incurred for the home study, costs of physicals required for the home study, costs for criminal records checks. Legal fees related to the termination of parental rights or a voluntary surrender of parental rights are not covered.

How much may be reimbursed? Every eligible child may receive up to $2,000 for these expenses.

What if the child isn't in the custody of DHR? As long as the child has been determined special needs by the State Adoption Unit prior to finalization and the prospective adoptive family has entered into an agreement with DHR prior to finalization, a child is eligible (with the exceptions outlined above).

What forms are completed for this benefit? Form 402 is the form that is utilized when the child is receiving recurring/monthly benefits. If a child is eligible only for non-recurring adoption expenses, Form 402A is used. A narrative must be completed that identifies the child's special needs and efforts to place the child without non-recurring adoption assistance.

What if the adoption disrupts after the family contacts an attorney? No expenses are reimbursable unless the adoption has finalized.

(Adoption Policy Manual 109.21 and 109.22)

NON-RECURRING ADOPTION ASSISTANCE NARRATIVE

Amanda Smith

Mr. and Mrs. Smith have adopted an eight year old child from Russia. They are asking for the maximum amount of reimbursement for the expenses relating to the adoption.

Amanda Smith is a Caucasian female who was eight years of age when placed with the Smith's. Her date of birth is January 2, 1997. Enclosed is a copy of all court papers which indicate the rights of both of her parents were voluntarily surrendered. Amanda was adopted on October 15, 2005.

Mr. and Mrs. Smith have indicated they could not have adopted Amanda without the assistance from the Adoption Assistance program.

Enclosed are copies of the receipts the family has submitted.

Georgia Department of Human Resources

NON-RECURRING ADOPTION ASSISTANCE AGREEMENT

(This form is for children eligible for non-recurring expenses only, see Adoption Manual Section 109)

The following agreement has been entered into by and between:

State Agency/Other Relevant Agencies

Address / Telephone Number

hereafter called the "agency(ies)" and

Adoptive Parent(s)' Full Name(s)

Address / Telephone Number

hereafter called the "adoptive parents"

for the purpose of assisting the adoptive parents with reimbursement of the expenses related to the finalization of the adoption of:

Child's Name

Date of Finalization

Attached to this request is documentation of the child's special needs, verification that the child is legally free for adoption and documentation, in narrative form, of efforts to place without assistance. Application must be signed and approved prior to the finalization of the adoption. Verification of finalization must be included. Payments may not be made until the adoption is finalized.

* * * * * *

Adoptive Mother's Signature — Date

Adoptive Father's Signature — Date

Authorized Agency Representative's Signature / Title — Date

County Director / Designee's Signature — Date

DHR

B.J. Walker, Commissioner

Georgia Department of Human Resources • Division of Family and Children Services • Adoption Unit
2 Peachtree Street, N.W • Suite 8-400 • Atlanta, GA 30303-3142 • Phone: 404-657-3550 • Fax: 404-657-9498

MEMORANDUM

TO: County Director
Terrell County DFCS

FROM: Adrian J. Owens
Policy Specialist
Post Adoption Services

RE: **Brandy Smith** **DOB: 2/26/2002**

DATE: **December 29, 2005**

This child (is) (is not) registered as a child with special needs for the purpose of Adoption Assistance based on age.

If this child has background factors only, have the family sign a deferred Adoption Assistance Agreement to be kept on file. Please inform the family that future consideration for Adoption Assistance will be determined by the State Adoption Unit.

cc: Adrian Owens

(Manual Reference: 109.3)

Special Services Adoption Assistance

What are special services? Special services are funds that are utilized for a time limited or one time expense. As these are solely state funds, approval is dependent on their availability.

Who may receive special services funds? Children who have been in the permanent custody of DHR or were placed in an adoptive home by DHR as the result of a TPR initiated by DHR. Funds are available up to age 18.

What type of services can be purchased through special services adoption assistance? Services that are related to the special needs of the child that are not available through family resources, monthly adoption assistance, community resources or Medicaid. There must be documentation of the need for these services, i.e. psychological counseling that exceeds the limits provided under Medicaid, orthodontics not covered by Medicaid, child care for families whose gross income falls within the designated guidelines as outlined in the adoption policy manual section 109.19.

What if a child receives a higher level of adoption assistance? Any income available to the family and the child is factored into a request. A family may be asked to specify why they are unable to provide for a specific service they are requesting.

How do you apply for special services funds? Once a family has requested a service and provided the documentation of the need for the service, the cost of the service and the expected duration of the service, they will need to complete form 24 and form 44. The SSCM will write a narrative outlining the need for the request and this information will be submitted to the state adoption unit for approval or denial.

May a service be paid for even though a family has requested it after it has been provided? No, all requests must be pre-approved based on the necessity of the request and the availability of funds.

(Adoption Policy Manual Sections 109.19 and 109.20)

SPECIAL SERVICES ADOPTION ASSISTANCE NARRATIVE

Susie Jones

Susie Jones receives the minimum amount of adoption assistance for a child her age. She has increased problems with attention deficit and hyperactivity. Her pediatrician has recommended she begin counseling in addition to drug therapy to treat the ADHD.

Susie is involved in therapy on a weekly basis and she also takes the drug, Concerta. Although she has begun to show improvement in some areas, she continues to be in need of therapy. She is in need of tutoring, which has been recommended by her therapist and her teacher, as the ADHD has negatively impacted some of her learning. As Susie and her family reside out of state, the tutoring services offered through the state contract are not available to her.

Enclosed are the recommendations for tutoring from her teacher and therapist. The letter from the school indicating the school system will not provide additional tutoring and information from the provider who is a certified tutor. The cost for tutoring is $10 per hour and the provider has indicated the services are necessary a minimum of once per week for six to eight months.

Mr. and Mrs. Jones have completed their financial information and have indicated they have tried unsuccessfully to locate community resources that could assist with this service. They have also indicated that the majority of Susie's adoption assistance pays for her extra-curricular activities, i.e. cheerleading and guitar lessons.

The agency recommends the approval of this request in the amount of $750.

Georgia Department of Human Resources

SPECIAL SERVICES ADOPTION ASSISTANCE AGREEMENT

The following agreement has been entered into by and between

The Georgia Department of Human Resources

_____ County Department of Family and Children Services

_____ / _____

Caseworker's Name — Telephone Number

_____

Address

AND

_____

Adoptive Parent(s)' Full Name(s)

_____ / _____

Address — Telephone Number

For Services provided to:

_____ Amount of Monthly Adoption Assistance Benefits _____

Child's Name

Service Requested _____ Amount Requested _____

Approval Period: ____/____ to ____/____

Month Year Month Year

The signing of this Agreement by the adoptive parent(s) confirms the parent(s) has tried to obtain this service through community resources, insurance or personal financial resources and is unable to secure/provide for this special need of the child without special services adoption assistance funds. The approval of these funds by the Department of Human Resources is for the designated period, not to exceed 12 months. Any subsequent requests for special services adoption assistance funds will need to be requested and pre-approved prior to any additional funds being provided to the child. Approval is contingent on the availability of funds.

* * * * * *

_____ _____

Adoptive Mother's Signature — Date

_____ _____

Adoptive Father's Signature — Date

_____ _____

Agency Representative's Signature — Date

_____ ☐ Amount Approved_____ _____

State Adoption Unit Representative's Signature ☐ Denied — Date

If request is denied, reason for denial:

_____

Attachments To Be Included: Narrative and Supporting Documentation

Georgia Department of Human Resources

FINANCIAL STATEMENT FOR RESOURCE PARENTING

		Date:
Family Name:	Father:	Mother:
Father's Occupation:		
Name and Address of Employer:		
Date Employed:	Monthly/Yearly Gross Salary:	
Mother's Occupation:		
Name and Address of Employer:		
Date Employed:	Monthly/Yearly Gross Salary:	
Other Household Income:		
Home: ☐ Owned ☐ Rent	Monthly Payment/Rent:	
Amount of Mortgage:	Approximate Market Value:	
List all other Assets:		
Total Amount of Assets: (Including House)		
Life Insurance:		
Father:		
Mother:		
Health Insurance:		
Is an adopted child covered from date of placement:	Yes ☐ No ☐	
Is there a waiting period for pre-existing conditions:	Yes ☐ No ☐	

FINANCIAL STATEMENT FOR RESOURCE PARENTING

List All Outstanding Debts: (show total owed and monthly payments) Attach additional page if needed.

(Name of Creditor)	**(Total Owed)**	**(Monthly Payment)**
Credit Card(s):		
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
Automobile(s):		
_____	_____	_____
_____	_____	_____
Bank Loan(s):		
_____	_____	_____
_____	_____	_____
_____	_____	_____
Furniture/Appliance(s):		
_____	_____	_____
Student Loan(s):		
_____	_____	_____
Other (list):		
_____	_____	_____

Monthly Expenses: (List all monthly expenses by name and amount) Attach additional page if needed.

(Monthly Expense)	**(Amount of Expense)**
Rent/Mortgage:	_____
Electricity:	_____
Gas:	_____
Water:	_____
Sewage:	_____
Telephone:	_____
Insurance:	
Automobile:	_____
Home:	_____
Health:	_____
Dental:	_____
Life:	_____
Medical and Prescription Expenses:	_____
Cable Television:	_____
Internet Service:	_____
Cell Phone:	_____
Groceries:	_____
Clothing:	_____
Tithes/Charitable Contributions:	_____
Child Support:	_____
Day Care:	_____
Other (list):	_____

Total Monthly Income (after withholding): _____
(-) Total Monthly Payments and Expenses: _____
(=) Available Monthly Surplus: _____

DURATION OF BENEFITS

MONTHLY ADOPTION ASSISTANCE: these benefits terminate at the end of the month of the child's 18th birthday with the following exceptions:

a. If the child was placed on adoptive status prior to June 1998, the child may continue to receive benefits (all benefits will be from state funds) if the child remains in high school, college or technical. All benefits, regardless of school status terminate when the child finishes school or turns age 21, whichever occurs first. The child must be attending school on a full-time basis which must be verified by quarter or semester, whichever is applicable.
b. If the child was placed on adoptive status after June 1998, the child is eligible to receive benefits until the child finishes high school or turns age 21, whichever occurs first. The child must be attending school full-time with verification the same as in section a. **OR**
c. **If the child was placed at age 13 or older, the child may continue to receive benefits until the child finishes high school, college or technical school or turns age 21, whichever occurs first.** Verification of attendance is the same as section A and B.

SPECIAL SERVICES ADOPTION ASSISTANCE: these benefits are available **only** to children who have been in the permanent custody of DHR or who are placed with a specified relative for the purpose of adoption as the result of a TPR filed by DHR. These benefits terminate during the month of the child's 18th birthday.

MEDICAID: these benefits are available to any child eligible for adoption assistance benefits. If the funding category changes to state funded, the medical benefit shall change to this category also.

NON-RECURRING ADOPTION ASSISTANCE: these benefits are available for any child who is special needs (with the exception of those adopted by birth parents or step-parents) until age 18. Benefits must be applied for prior to the 18th birthday. After age 18 an adoption would be considered an adult adoption.

Children who have never been in the permanent custody of DHR (independent or relative adoptions) may receive benefits only if they meet Title IVE criteria. All benefits for non-DHR children terminate at age 18.

All Title IVE AA benefits become state funded once a child turns 18.
(Adoption Policy Manual Section 109.10 and 109.11)

Renewals for Adoption Assistance and Medicaid

DHR requires an annual review of Adoption Assistance cases. This is not a federal requirement, but is state policy. However, there is a federal requirement to review Medicaid annually.

As the majority of children who receive AA also receive Medicaid, this review is coordinated between Social Services and the Office of Financial Independence.

The purpose of the review for Social Services is to verify whether or not the family continues to be legally and/or financially responsible for the child and whether or not the family is in need of any information/referral for services for the child's special needs.

The review date will coincide with the date of initial certification every year.

Procedure:

The SSCM will send Form 28, Adoption Assistance Renewal Form, to the family sixty (60) days prior to the end of the first year and subsequent years of eligibility.

Case manager sends returned Form 28 and Form 227 (if there are any changes to report) to the Medicaid Eligibility Specialist in the Revenue Maximization Unit. Copies of these two forms are maintained in the AA case record.

Once the Medicaid Eligibility Specialist has completed the renewal process for Medicaid, the social services case manager will be sent a Form 225 which identifies findings regarding continued eligibility for Medicaid. This form is too retained in the AA case record.

If the family fails to return the Form 28, adoption assistance benefits may be held until the form is received.

(Adoption Policy Manual Section 109.27, Volume II/MA, MT 17-10/05)

Georgia Department of Human Resources

ADOPTION ASSISTANCE RENEWAL FORM

Date Mailed: _____

Name of Parent(s): _____

Mailing Address: _____
_____
_____

Dear _____

Each year we will contact you regarding your child(ren)'s Adoption Assistance benefits. Please complete this form and return it within thirty (30) days in order for your children's medical benefits to continue. Your renewal period is from:_____ to _____.

Child(ren)'s Names: (1) _____ (4) _____
(2) _____ (5) _____
(3) _____ (6) _____

1. Has this child lived in your home during the past year? If not, where has the child resided?
   1 ☐ Yes ☐ No _____
   2 ☐ Yes ☐ No _____
   3 ☐ Yes ☐ No _____
   4 ☐ Yes ☐ No _____
   5 ☐ Yes ☐ No _____
   6 ☐ Yes ☐ No _____

2. Is your child covered under an insurance plan? Military medical benefits? SSI? Please identify the plan
   _____

3. Would you like information on meeting the special needs of your child(ren)? ☐ Yes ☐ No
   If yes, please indicate the special needs below:
   _____
   _____
   _____

We understand that Adoption Assistance benefits will continue to be provided to our child(ren) according to the terms outlined in our initial Adoption Assistance Agreement.

_____ _____
Adoptive Father's Signature Date Adoptive Mother's Signature Date

RETURN TO: Case Manager's Name _____
County DFCS _____ Telephone Number _____
Address _____

A copy of this agreement shall be maintained in the Adoption Assistance record. For families requesting information, it must be documented that information/referral was provided and what resources were identified.

GEORGIA DEPARTMENT OF HUMAN RESOURCES

NOTIFICATION OF CHANGE IN FOSTER CARE OR ADOPTION ASSISTANCE

Child: _____ Medicaid #: _____

Date: _____

Court Order Language "*Reasonable efforts to finalize"*	_____ Judicial determination was made on this date: _____ _____ Date of the court order with the required language is: _____ _____ Judicial determination was **NOT** made because: _____ It was omitted from the court order; _____ The court found that DFCS had **NOT** made "*reasonable efforts*"; _____ The finding was not timely; i.e., within 12 months
Foster Care Placement	_____ Child was placed in a fully approved/licensed facility effective: _____ Name/Address: _____ _____ Child moved to the above placement from another IV-E reimbursable home/facility? o No o Yes***** ** To avoid two IV-E payments on the same day(s) of the child's move or concurrent placement, indicate in "Comments" the Name/Address of the prior home/facility and the date(s) of the IV-E payment.* _____ Child placed in a **NON** IV-E approved placement effective: _____ Name/Address: _____
Adoption Assistance	_____ Adoptive placement effective date: _____ _____ Adoption petition filing date: _____ _____ Adoption finalized as of date: _____
Parental Deprivation	_____ A change occurred in more or more of these "deprivation factors" in the removal home: o Absent parent returned o Parent deceased o Parent disabled/incapacitated o Parent unemployed o TPR/Surrender of parental rights Parent effected by this change: o Father o Mother Effective date: _____
Income/Resources (child's)	_____ There was a change in the child's income in the amount of $ _____ received from: o SSI o Child Support o VA Benefits o Social Security o Personal earnings o Other (specify): _____ _____ The child acquired resources total valued at : $ _____ Source(s): _____
Age	_____ This child reaches (or has reached) age 18 on (date): _____
Legal Responsibility	_____ Effective Date _____ DFCS no longer has legal responsibility for the child because: o Custody order expired o DFCS was relieved of custody o Other (explain): _____ _____ DFCS re-instated its expired order effective (date): _____
VPA	A judicial determination that continuation in foster care is in the "best interest" of the child: _____ Was obtained from the court within 180 days of placement _____ Was NOT obtained from the court within 180 days of placement. Effective date: _____
Trial Home Visit	The child's trial home visit exceeded 6 months or the time frame authorized by the court. Effective date: _____
Comments	

SSCM/JPPS signature: _____ CL#: _____ County:_____

SSCM/JPPS Printed Name: _____Telephone No.: ( )_____

Form 227 (Rev. 10/05) Original – Services Record (Fax) Revenue Maximization Regional Office

Module Six

Special Considerations

SPECIAL CONSIDERATIONS/THINGS YOU NEED TO REMEMBER

Special Needs Determinations-All cases need a special needs determination. For the DHR child this needs to occur prior to adoptive placement. In the event a family is requesting non-recurring adoption expenses only, the determination must be made prior to finalization. If a child is a non-DHR child, this determination must be made prior to finalization.

Specialized Rates-(formerly Level of Care)-Case managers should submit the request for a determination for a higher per diem at least two months prior to placement. The family needs to know how much a child is to receive as this may differ from the current rate-particularly if the child is stepping down from a therapeutic placement into family foster care. A specialized rate is a rate based on family foster care. No child may receive an amount of assistance based on anything other than a family foster care board rate.

All rates for assistance must be made prior to adoptive placement (unless a non-DHR child whose rate must be determined prior to finalization). No exceptions may be made to this unless the child resumes foster care status and is replaced on adoptive status prior to the finalization.

Adoption Assistance Agreements-All agreements must be signed by the family and the agency representative prior to the finalization of the adoption. There are no exceptions to this. If the signatures on the agreement are obtained at separate times, the later date of signature will be considered the effective date of benefits. If this date differs from the placement date, the child will not be eligible for monthly assistance or Medicaid until the later date. If the agreement hasn't been signed, the family will need to have a fair hearing. If a deferred agreement has been signed and cannot be located, the family will need to request a fair hearing.

IMPORTANT: A FAMILY MAY REQUEST A FAIR HEARING FOR MANY REASONS. Some families will request retroactive payments if the OSAH decision is favorable to them. We do not provide for this. (Adoption Policy Manual Section 109.28 #3)

Adoption Assistance Narrative: This is a very important part of the entire AA package. Federal law requires each case to contain a narrative, whether the request is for recurring adoption assistance benefits or non-recurring adoption assistance

benefits only. All narratives must identify the child's special needs and what efforts have been made to place a child without adoption assistance. **If this information is not contained in the record and there is an audit, this would be considered an error.**

Foster care per diem increases-These increases may or may not be reflected in the monthly adoption assistance benefits.

All federally funded benefits terminate at age 18. If a child remains eligible, he or she may receive Medicaid and adoption assistance under state funds. However, special services adoption assistance benefits will not be available past age 18.

SSI-If a child receives SSI benefits, the amount of SSI will be reduced dollar for dollar of the amount of adoption assistance the child receives. SSI benefits will be based on the child's income until finalization. Once finalized, the adoptive parent's income will be considered also. The receipt of adoption assistance must be reported, in writing, to the Social Security Administration by the SSCM.

Changes-All changes must be reported to Revenue Maximization Unit and to the State Adoption Unit.

Children who have been adopted but are in a residential placement funded through DHR may continue to receive adoption assistance funds for personal items or any costs incurred by the adoptive parent. The parent is required to participate towards the cost of the placement on a monthly basis. If there is no financial participation, funds shall be suspended until the family resumes financial responsibility for the child.

(Adoption Policy Manual Section 109.5)

October 21, 2004

Susie Sunshine, Director
Essex County Department of
Family and Children Services
123 Fourth Street
Timbucktwo, Georgia 33333

RE: Gillicuddy, Mac and Maxine
111 Twentieth Street
Timbucktwo, GA 33333

Jeremy DOB 4-2-03
Gabrielle DOB 2-28-02

Dear Ms. Sunshine:

Enclosed please find the adoption assistance case record for the above-named family. Mr. and Mrs. Gillicuddy finalized the adoption of Jeremy and Gabrielle on June 15, 2004. Both of the children receive state funded adoption assistance in the amount of $410.33 per month. The current certification period ends on July 31, 2005.

We will continue to issue the adoption assistance check through December 2004. We will notify Mr. and Mrs. Gillicuddy that the January 2005 check will come from your office. Please call us at (111)222-3333 if you need additional information.

Thank you for your assistance with this family.

Sincerely,

Social Services Case Manager

Social Services Supervisor

CC: State Adoption Unit
DeKalb County DFCS Bookkeeping

Transferring Cases Between Counties

Case Manager in the referring county shall do the following when transferring a case:

A) Notify the new county of residence in writing of the transfer of the adoption assistance case record.

B) The referring county will continue to pay adoption assistance payments for two months prior to transfer of payments.

1) Prior to transfer the SSCM must have all case information current to the date of transfer (i.e. renewals, special services requests).

C) Notify Revenue Maximization of the transfer via form 227.

D) Notify the State Adoption Unit of the transfer by sending a copy of the transfer letter and Form 403 to the Policy Specialist in the State Adoption Unit.

E) Notify accounting of the impending change of residence.

F) The referring county will continue to make adoption assistance payments to the family for the next two months.

G) In the event the adoption assistance case record is returned to the referring county, the referring county will continue to pay the adoptive family until the required information is made available to the record and the receiving county has accepted the record for future maintenance.

The receiving county is responsible for the following:

A) Review of the case record to ascertain whether or not all appropriate information and documentation regarding the case is in the record.

1) If the correct information is not available, the new county of residence shall return the adoption assistance case to the referring county until the record is current and complete.
2) No adoption assistance will be made by the receiving county until the record is returned and contains the required information.

B) The receiving county shall contact the adoptive family and inform them of whom to contact in the event any services or information is needed regarding adoption assistance, Medicaid and post adoption services.

C) The receiving county shall notify accounting of the receipt of the adoption assistance case and when the payments shall begin.

Module Seven

Post Adoption Services

Post Adoption Services Program

Adoption is a lifelong process. In order to support this process and maintain the adoptive family unit, the State of Georgia has implemented several post adoption programs. In addition to these contracted programs, some services may be obtained through Special Services Adoption Assistance funds.

Each of the programs identified here may be utilized by families who have adopted children through DHR. If availability allows, families who have adopted children from other agencies may utilize these services also. The Georgia Center for Resources and Support is available to any foster and adoptive family. Only the Adoption Reunion Registry requires a fee for services.

Legal Basis

Adoption and Safe Families Act (ASFA) -Title III, Section 305 –Promoting Safe and Stable Families Program. Twenty percent of a state's allotted program funds are to include adoption promotion and support services.

OCGA 19-8-23-Reunion Registry

Post Adoption Services Programs

Adopted Teen Empowerment and Mentoring (ATEAM)

This program is designed for adopted teens in 6th – 12th grades to promote self-expression through interactions with other adopted teens. Meeting times are on Saturday, once a month (10 a.m. – 5:00 p.m.) in each of the twelve regions across the state. Parents are encouraged to participate in their own support groups while the teens are meeting. Information regarding this program is provided by mail to all AA recipients. Information may also be accessed through the Georgia Center for Resources and Support either by phone or their website.

Camp Promise

Ten week long camps are offered across the state to adopted children with special needs, ages 9 – 17. Every adoption assistance recipient receives information from the provider regarding application for the camps. Acceptance is on a first come first serve basis due to capacity limitations. Information regarding this program is provided by mail to all AA recipients. Information may also be accessed through the Georgia Center for Resources and Support either by phone or their website.

Crisis Intervention Team

The Intervention Team provides early intervention to decrease disruptions, dissolutions and preserve the adoptive family. The team provides both in-home assistance and referral to appropriate community resources. Case management activities remain available until the crisis has stabilized. Referrals for this service must be initiated by the County Department Case manager and submitted for review and approval/denial to the State Adoption Unit. Referral information is located in Appendix K of the Adoption Policy Manual.

Georgia Center for Resources & Support

The Center connects foster and adoptive families to community resources that are available to families to assist in meeting the needs of the children and families in who are joined through foster care or adoption. Every region of the state has an advisor who is available to families seeking assistance. Some of the services are the identification of specific community resources for special needs children, lists of Medicaid providers, development of support groups, a lending library, a web site that offers on-line learning, a chat room and a calendar of events for foster and adoptive families. Access for services is either by phone at 1-866-A-Parent or www.gacrs.org.

Adoption Reunion Registry

Georgia's Adoption Reunion Registry offers the following services to birth parents, adopted persons and adoptive parents:

- Non-identifying information for adoptees
- Searches for birth parents by adult adoptees
- Searches for adult siblings separated by adoption
- Requests by birth parents to release or withhold identifying information
- Information and referral to support/search groups in Georgia and out-of-state
- Counseling and intermediary services

Contact with the Registry is made by calling their direct number at 404-657-3555 or 1-888-328-0055. There is a $35 fee for non-identifying information and a $300 fee for a search for birth parents or siblings. Registration is free for birth parents, adopted persons and siblings.

(Adoption Policy Manual Section 111 and Appendix K)

Georgia
MENTOR
Bringing Caring Closer

INTERVENTION TEAM REFERRAL FORM

Directions: Please complete this form and fax it to 404-657-9498 ATTN: Adrian Owens. Please allow 72 hours for the family and Case Manager to be contacted via phone.

Date of Referral_____ Child's Legal county_____ Fax_____
Child(ren)'s CM_____ Phone_____ Pager_____

Supervising County of
Adoptive Parents_____ Family's CM_____

Phone_____ Pager_____ Fax_____

Name of Adoptive Parent(s): _____ DOB_____ County_____

_____ DOB_____

Address_____City_____Zip_____

Phone_____ work/alternate phone or pager_____

Circle: mother father

Name of adoptive child(ren) **Diagnosis**

1)_____Age_____ DOB_____ M F Race_____ _____

2)_____Age_____ DOB_____ M F Race_____ _____

Substantiated history of **A**buse or **N**eglect?_____

Others living in the home and relationship to child(ren)_____
_____

Person who advised family of contact by Adoption Intervention Team_____
_____

Child(ren)'s history of problematic behaviors: (refer to by number next to child's name).

___sexual acting out	___difficulty with attachment	___depression
___current suicidal ideation/gestures	___ previous suicidal ideation/gestures	___ fire setting
___running away	___ destroying property	___ aggression
___alcohol/drug use	___ oppositional	___ stealing

Other (use # to indicate child):_____
_____

Indicate any recent medication changes in any family members:_____

Significant issues within the family: __ illness __death __financial __ limited supports __ parental rigidity
__ unrealistic expectations of child Other:_____

Previous adoptive disruptions? Y N If so, indicate child by #_____

Did the adoptive parent(s) serve as foster parent(s) to the child(ren)? Y N
Did the adoptive parent(s) have previous experience as foster parent(s)? Y N
Is this a kinship placement? Y N Indicate relationship:

For finalized placements, please ask parents to make copies of child's history and previous psychiatric and psychological evaluations prior to the first home visit.

Name of Family:_____

Explain current situation and reason for referral:

Any additional information needed prior to family contact:

Referring case manager_____

Title_____

Referring Placement Coordinator: ___ Ann Deibel _____

___ Sheila Waterman _____

___ Adrian Owens _____

___ Kalean B. Thompkins_____

CC: RAC_____

Module Eight

Post Finalization and Fair Hearing Requests

ADMINISTRATIVE/ FAIR HEARING REQUESTS

The following is a list of possible extenuating circumstances warranting a fair hearing:

a. The agency has failed to provide known relevant facts regarding the child to the adoptive parents.
b. Adoption Assistance was denied on the basis of a means test.
c. An adoptive family disagrees with the State's determination of the child's ineligibility (i.e. the child is not special needs).
d. The state has failed to advise potential adoptive parents about the availability of adoption assistance.
e. The amount of adoption assistance was decreased without parental consent.
f. An adoptive family has requested a change in the payment level of adoption assistance due to a change in their circumstances and this request has been denied.

If the adoptive family does not have a signed adoption assistance agreement, one must be completed and denied.

All denials and requests for fair hearings shall be in writing.

Attached are the forms needed to request a fair hearing.

After completion, the forms shall be routed as follows:
One copy to the Adoption Assistance Policy Specialist
Two copies to DHR Legal Services
One copy for the case record
Once copy to the family

(Adoption Policy Manual Section 109.28)

OSAH FORM 1

Date: _____

Name of Referring Agency: _____ **County Department of Family and Children Services**

Individual in Referring Agency who may be contacted about this matter:

_____ _____ _____ _____
Name Address Phone Fax

Party Initiating the Hearing (Claimant): _____

Is the Hearing Request Attached? ☐ No ☐ Yes

Issues to be Resolved: (Outline the legal issues and factual matters to be resolved at the hearing. Reference any policies/supporting documentation, which explains the decision/action of the agency, and attach copies of the same.)

_____

Special Requirements for OSAH: A hearing must be conducted and a decision issued within 90 days of the date the county department received the hearing request.

Instructions: Use as a cover sheet for each package of documents/forms (original and 2 copies) being submitted. Send to: DHR Legal Services Office; ATTN: Appeals Reviewer; 2 Peachtree Street, NW; Room 29.231; Atlanta, GA 30303

Georgia Department of Human Resources
Georgia Department of Human Services
REQUEST FOR ADMINISTRATIVE HEARING – PLACEMENT

The Office of State Administrative Hearing (OSAH) is required to review the action or inaction of the _____, which is an agency of the Division of Family and Children Services and is located at:

_____ _____
Address City
in regard to making available to me the social service(s) listed below:

- ☐ Denial of the service(s)
- ☐ Reduction of the service(s)
- ☐ Termination of the service(s)
- ☐ Denial of visitation or transportation to visitation
- ☐ Reduction of visitation or transportation to visitation
- ☐ Termination of visitation or transportation to visitation

Explain _____

_____ _____ _____ _____ _____
Signature of Claimant Address City Zip Code Phone

_____ _____ _____ _____ _____
Signature of Witness Address City Zip Code Phone

The information below is to be completed by Local Agency and OSAH

Local Agency:

Claimant's Name (typed) _____ Case ID No. _____

Date Oral Request Received _____ Date on Notification Form _____

Date of Written Request _____

Client's Representative (if any) _____ _____ _____
Name Address Phone No.

Agency Contact _____ _____ _____
Name Address Phone No.

Office of State Administrative Hearings:

Date Request Received: _____

Instructions: Mail original Hearing Request and copies of all documents/ forms to:
DHR Legal Services Office
Attn: Appeals Reviewer
2 Peachtree Street, NW Room 29.231
Atlanta, Georgia 30303-3142