**Adoption Assistance Annual Information Update**

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

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

**FAMILY INFORMATION**

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| --- | --- | --- | --- | --- |
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Family Last Name Parent’s Name Parent’s Name

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

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

**Name of Child(ren)**

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Child (1) |  | Soc. Sec. #: |  | Age: |  | DOB: |  | Male | Female |
| Child (2) |  | Soc. Sec. #: |  | Age: |  | DOB: |  | Male | Female |
| Child (3) |  | Soc. Sec. #: |  | Age: |  | DOB: |  | Male | Female |
| Child (4) |  | Soc. Sec. #: |  | Age: |  | DOB: |  | Male | Female |

1. Is the child **currently** living in your home? **for the past 12 months**? If no to either question, please explain **below** and on **page 2**.

|  |  |  |  |
| --- | --- | --- | --- |
| Child (1)  Yes  No | If no, explain: |  | DFCS Notified:  Yes  No  N/A |
| Child (2)  Yes  No | If no, explain: |  | DFCS Notified:  Yes  No  N/A |
| Child (3)  Yes  No | If no, explain: |  | DFCS Notified:  Yes  No  N/A |
| Child (4)  Yes  No | If no, explain: |  | DFCS Notified:  Yes  No  N/A |

1. If the child is covered under a type of insurance **other than Adoption Assistance Medicaid or Amerigroup**, list it below:

**Also, please send a copy of insurance card(s) with this form, if other than Medicaid or Amerigroup.**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Child (1) Provider Name: |  | Group #: |  | Member #: |  | Primary Person: |  |
| Child (2) Provider Name: |  | Group #: |  | Member #: |  | Primary Person: |  |
| Child (3) Provider Name: |  | Group #: |  | Member #: |  | Primary Person: |  |
| Child (4) Provider Name: |  | Group #: |  | Member #: |  | Primary Person: |  |

1. Does the child receive SSI based on his/her disability from the Social Security Administration?

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| --- | --- |
| Child (1)  Yes  No If Yes, How much monthly? |  |
| Child (2)  Yes  No If Yes, How much monthly? |  |
| Child (3)  Yes  No If Yes, How much monthly? |  |
| Child (4)  Yes  No If Yes, How much monthly? |  |

1. Has the child’s adoption been finalized? If not, when is the expected date for finalization of the adoption?

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

1. Are you in need of information or resources to assist in addressing the special needs of your adopted child(ren)? If so, please indicate the need below (you may also contact the PAD Manager or Case Manager listed at the bottom of this page):

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

**\*** Please do not hesitate to contact the person listed below if you have any questions or to report any of the above circumstances.

Use the space below to notify DFCS of any current or expected future changes, like the ones mentioned above, as required:

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

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| --- | --- | --- |
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Adoptive Parent’s Signature Date Adoptive Parent’s Signature Date

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

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

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

Thank You.