The following information will help you in filling out the attached worksheet to apply to the Adoption Support Program and provide information on your child’s special needs and your family’s circumstances. Please complete a worksheet for each child you are applying for. Once completed, the worksheet will be reviewed by the Adoption Support Program Consultant.

Please first enter the name of the child to be adopted, your name(s) and the date you are completing the form.

**SECTION 1: CHILD’S SPECIAL NEEDS AND RELATED EXPENSES**

Enter the following information:

* **Child’s Special Needs and Related Expenses** is where you list the name of the identified expense (ie. Basketball, adaptive equipment, sensory tools/etc.)
* **Monthly Expense** is where you list the total monthly expense related to your child’s special need(s)
* **Amount Provided by Parent** is the portion of the monthly expense your family is able to provide post-adoption
* **Amount Assistance Requested** is the portion of the total expense your family is requesting Adoption Support assist with

Example: A doctor or medical/mental health professional recommends extracurricular activities such as swimming lessons, martial arts or sports to address your child’s gross motor, sensory, peer relationship or other special need. Specifically, your child is enrolled in Taekwondo at $50/month, and a sports-related summer camp at $840 for 8 weeks\*. Based on your budget, you feel your family is able to cover half of the cost of these expenses, and request that Adoption Support assist with the other half.

**\*TIP**: We encourage your family to sit down and review your budget and expenses to get a realistic idea of the amount of financial resources your family is utilizing on a monthly basis to support your child’s special needs. We recognize not all expenses happen monthly, but reviewing and thinking about expenses within a year can help you to think about those expenses that happen bi-monthly, twice a year, or only once a year. In the above example, the family would take $840 divided by 12 months = $70/month for this expense.

|  |  |  |  |
| --- | --- | --- | --- |
| **Section 1. Child’s Special Need and Related Expenses** | | | |
| CHILD’S SPECIAL NEEDS AND RELATED EXPENSES | MONTHLY EXPENSE | AMOUNT PROVIDED BY PARENT | AMOUNT ASSISTANCE REQUESTED |
| **Taekwondo** | **$150** | **$75** | **$75** |
| **Summer Camp** | **$840/year = $70/month** | **$35** | **$35** |

**SECTION 2: FAMILY AND COMMUNITY RESOURCES**

Please fill out this section as completely as possible, based on what applies to your family. This section is intended to provide the Adoption Support Program with information to consider your family’s overall ability to integrate this specific child into your home post-adoption, with their specific needs.

**\*TIPS:**

* The number of people supported by the applicant’s income and resources should \*not\* include any foster children currently in the home. The child(ren) to be adopted should be included.
* Gross monthly income is the income before taxes, insurance, and other deductions
* Additional sources of income may include child support, funds from Social Security benefits for yourself or your child(ren), veteran benefits, per capita, etc.

**SECTION 3: AVERAGE EXPENSES**

Please fill out this section as completely as possible, based on what applies to your family. This section is also intended to provide the Adoption Support Program with information to consider your family’s overall ability to integrate this specific child into your home post-adoption, with their specific needs.

* Do your best to provide an average and accurate amount of all the monthly fixed and variable expenses your family is responsible for.
* If you have another method of providing your family budget (Word document, Excel document, etc.) you are welcome to attach that instead. You can also attach additional paper to the Adoption Support Worksheet.

**SECTION 4: REQUESTED BENEFITS**

In this section, you are identifying whether you are able to adopt this child without the assistance of the Adoption Support Program, and if not, which of the (4) benefits of the program you are requesting. You are able to request any combination of the benefits that best fit your family’s needs.

Please first identify your ability to adopt this child without the assistance of the Adoption Support Program. The Adoption Support Program is available for those families who are unable to adopt this child without the assistance of the program (Most families are unable to adopt without at least (1) of the provided benefits).

Please then identify which of the benefits you are requesting:

* **Monthly cash payment:** Check the box if requesting, and indicate the dollar amount you are requesting from the program.
  + A monthly cash payment, if negotiated, may not exceed the statutory cap for the Adoption Support Maintenance Payment.
* **Non-Recurring Costs:** Check the box if requesting, and indicate the dollar amount of your anticipated non-recurring costs you are requesting reimbursement for (up to $1500.00 per child)
* **Counseling:** Check the box if requesting assistance with pre-authorized counseling
  + This benefit may assist financially to directly pay for some of the cost of mental health providers who are not contracted with the Medicaid insurance, or other insurance plan you may add your child(ren) to
* **Medical:** Check the box if requesting Title XIX Medicaid
  + If your family will be adding the child(ren) to their private insurance plan, Medicaid can be used as a secondary coverage

**\*TIP**: Please note that the overall intention of the Adoption Support Program is to combine with a family’s own resources, as well as community resources, to **assist** in covering the ordinary and special needs of the child. Cash payments, and benefits overall, are unique to every family and child.

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| NAME OF CHILD | | | NAME OF ADOPTIVE PARENTS | | | DATE | |
| **Section 1. Child’s Special Need and Related Expenses** | | | | | | | |
| CHILD’S SPECIAL NEEDS AND RELATED EXPENSES | | | MONTHLY EXPENSE | | AMOUNT PROVIDED BY PARENT | AMOUNT ASSISTANCE REQUESTED | |
|  | | | **$** | | **$** | **$** | |
|  | | | **$** | | **$** | **$** | |
|  | | | **$** | | **$** | **$** | |
|  | | | **$** | | **$** | **$** | |
|  | | | **$** | | **$** | **$** | |
| **Section 2. Family and Community Resources** | | | | | | | |
| Please list resources your family is currently accessing, or those services that are available, to offset the additional costs related to caring for your child. Examples are listed below. | | | | | | | |
| SOURCE | | | | | | AMOUNT | |
| Gross monthly income  Number of people supported by income: | | | | | | **$** | |
| Supplemental Security Income (SSI), Social Security (SSA) / Veterans Benefits | | | | | | **$** | |
| Child Support (for other children in the home) | | | | | | **$** | |
| Working Connections Child Care Co-pay | | | | | | **$** | |
| Other: | | | | | | **$** | |
| Family Medical Insurance List provider: | | | | | | | |
| Developmental Disability Administration and/or Medicaid Personal Care | | | | | | | |
| Birth to Three / Early Head Start / ECEAP / Developmental Preschool | | | | | | | |
| **Section 3. Average Expenses** | | | | | | | |
| MONTHLY EXPENSES | AMOUNT | | | MONTHLY EXPENSES | | AMOUNT | |
| Housing | **$** | | | Medical | | **$** | |
| Utilities / phone | **$** | | | Child Support | | **$** | |
| Food | **$** | | | Loans (not mortgage or rent) | | **$** | |
| Car | **$** | | | Credit card payments | | **$** | |
| Insurance | **$** | | | Dependent care | | **$** | |
| Family Medical insurance | **$** | | | Child care | | **$** | |
| Educational expenses | **$** | | | Other: | | **$** | |
| **Section 4. Requested Benefits** | | | | | | | |
| Adoption Support is an array of services and supports, including: Title XIX Medicaid, Pre-Authorized Counseling, Non-Recurring Cost reimbursement, and a Monthly Cash Payment, if negotiated. Can you adopt this child without the benefits of the Adoption Support Program?  Yes  No  If no, please indicate which of the below benefits you are requesting:  Monthly Cash Payment **$** (amount requested)  Non-Recurring Cost Reimbursement **$** (amount listed on application)  Pre-Authorized Counseling  Title XIX Medicaid | | | | | | | |
| ADOPTIVE PARENT SIGNATURE | | DATE | | ADOPTIVE PARENT SIGNATURE | | | DATE |
| **Extra Space if Needed** | | | | | | | |