

TITLE IV-E ADOPTION ASSISTANCE REQUEST

Please note that this adoption assistance request must be approved by the CYFD/PSD Adoption Support Manager prior to the adoption finalization through the court.

Worker:	Telephone:	
Tribe/Pueblo/Nation:		
Child:	DOB:	SS #:
Adoptive Parent:	DOB:	SS #:
Adoptive Parent:	DOB:	SS #:
Physical Address:		
Mailing Address:		
Telephone:		

Please provide the following information for each child.

Date child entered custody: _____ Date of Bio Parents' TPR/Relinquishment: _____

Placement type: _____ Relative _____ Non-relative Date child was placed in this home: _____

Indicate any of the following categories that apply to this child:

Over the age of five Member of a minority group
 Medical condition Physical, mental or emotional disability
 Member of a sibling group being adopted together

Please include the following documentation with this request.

Copy of child's birth certificate	Copy of child's social security card
Subsidy Negotiation Memo	Completed Adoption Assistance Information Sheet
Level of Care (FACTS) Foster Parent Payment	IV-E eligibility verification
Certificate of Indian Blood (CIB)	
Qualifying documentation if child is certified for specialized care (including medical, psychological, or other documentation for level of subsidy)	

Subsidy Information

Adoption Subsidy Amount Requested: _____

Legal Subsidy Amount Requested: _____

Medicaid Requested: _____ Yes _____ No

Form completed by: _____ **Date submitted:** _____