State of Kansas Department for Children and Families Prevention and Protection Services	**REFERRAL FOR ADOPTION ASSISTANCE** (To be completed by Contract Staff)	PPS 6110 REV 07/20

Section I

Child's Name:					Date of Birth:		
Current Placement:					Date Placed:		
Type of Care:					Contractor/Sub-contractor:		
Basic Daily Rate for Family FC:					Amount Paid To Placement:		
Difficulty of Care Payment: (Attach basis for decision)	☐	Yes	☐	No	Amount:		

Services purchased for/provided to child: ☐ Day Care ☐ Mental Health ☐ Physical Therapy ☐ Speech Therapy

☐ Respite Care ☐ Attendant Care ☐ Frequency ☐ Occupational Therapy ☐ Other

Does child receive SSI? ☐ Yes ☐ No Does child receive waiver services? ☐ Yes ☐ No

Has application been made? ☐ Yes ☐ No Type of Waiver:

Name of siblings to be placed with child:	Date(s) of Birth:
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Name of siblings to be placed with child:	Date(s) of Birth:

Section II

Adoptive Family:			
Address:	City:	State:	Zip:
Telephone #: (Home)	Work #:		
Relationship to child: (Mark One)	☐ Foster Parent ☐ Relative ☐ None		
Recruitment Efforts: (Attach all recruitment plans)			
Date of Adoption Staffing:	Date child presented to family:		
Date Adoption File Reviewed:	Anticipated Date of Placement:		
Income of Family:	Family Size:		
(Attach Budget)			

Section III

Factors or Conditions which make it reasonable to conclude the child cannot be placed without adoption assistance:

Provide written reports related to the physical/emotional/behavioral/mental/developmental diagnosis/disability completed within the last 12 months.

Refer to Appendix IJ in the PPS Policy and Procedure Manual for a listing of qualified factors or conditions.

	Age (Child must be 6 or older if considered alone)
☐	**Physical Disability:** **Date of Diagnosis:**

Disability Type:		Who Diagnosed:	
Disability Severity:		Implications for Parents:	
Treatment /Services Required:		Resources Available:	

☐ **Emotional/Behavior Disability:**

Date of Diagnosis:

Disability Type:		Who Diagnosed:	
Disability Severity:		Implications for Parents:	
Treatment /Services Required:		Resources Available:	

☐ **Mental/Developmental Disability:**

Date of Diagnosis:

Disability Type:		Who Diagnosed:	
Disability Severity:		Implications for Parents:	
Treatment /Services Required:		Resources Available:	

☐ **Other Identified Medical Conditions:**

☐ **MEMBER OF A SIBLING GROUP OF TWO OR MORE PLACED TOGETHER – One has special factor or condition.** Siblings name and condition:

Sibling groups of three or more do not require one child to have factor.

☐ **GUARDED PROGNOSIS: Genetic/Family**

Background Factors: *

☐ Mental/emotional disability/condition of parent: Who Diagnosed?

☐ Physical Condition/disability of parent: Who Diagnosed?

☐ Fetal alcohol spectrum disorder Who Diagnosed?

☐ Failure to Thrive (currently developmentally on target) Who Diagnosed?

☐ Multiple Placement Disruptions Number of Placements

Types of Placements:

☐ Other Basis for Disruptions:

For children eligible because of a guarded prognosis, payment will be deferred until special needs are manifested. Documentation of the specific factor shall be attached and maintained in the file.

The following documents have been attached to support the information provided above:

☐ Basic Child Assessment	☐ Adoption Staffing Report	☐ Adoptive Home Study
☐ Family Budget, if separate	☐ Medical Statement	☐ Psychologist/Psychiatrist Report
☐ I.E.P.	☐ Recruitment Plan	☐ Social History

Comments:

We certify we have advised the adoptive family the negotiation for adoption assistance is on a case by case basis between DCF and the family. The amount of assistance will be determined by the needs of the child and the family's access to resources available to meet the needs of the child. No amounts or type of assistance have been discussed.

Case Manager (name printed) Case Manager (signature) Date

Supervisor (name printed)	Supervisor (signature)	Date