

REFERRAL FOR ADOPTION ASSISTANCE

(To be completed by Contract Staff)

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)		<input type="checkbox"/> Yes	<input type="checkbox"/> No
Services purchased for/provided to child:		Amount:	
<input type="checkbox"/> Day Care	<input type="checkbox"/> Mental Health	<input type="checkbox"/> Physical Therapy	<input type="checkbox"/> Speech Therapy
<input type="checkbox"/> Respite Care	<input type="checkbox"/> Attendant Care	<input type="checkbox"/> Frequency	<input type="checkbox"/> Occupational Therapy
<input type="checkbox"/> Other			
Does child receive SSI?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
Does child receive waiver services?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
Has application been made?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
Type of Waiver:			
Name of siblings to be placed with child:		Date(s) of Birth:	
Name of siblings to be placed with child:		Date(s) of Birth:	
Name of siblings to be placed with child:		Date(s) of Birth:	

Section II

Adoptive Family:			
Address:		City:	State:
Telephone #: (Home)		Work #:	
Relationship to child: (Mark One)		<input type="checkbox"/> Foster Parent	<input type="checkbox"/> Relative
		<input type="checkbox"/> 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)	
<input type="checkbox"/>	Physical Disability: _____ Date of Diagnosis: _____
Disability Type:	Who Diagnosed:
Disability Severity:	Implications for Parents:
Treatment /Services Required:	Resources Available:

<input type="checkbox"/>	Emotional/Behavior Disability: _____		
	Date of Diagnosis: _____		
Disability Type:		Who Diagnosed:	
Disability Severity:		Implications for Parents:	
Treatment /Services Required:		Resources Available:	
<input type="checkbox"/>	Mental/Developmental Disability: _____		
	Date of Diagnosis: _____		
Disability Type:		Who Diagnosed:	
Disability Severity:		Implications for Parents:	
Treatment /Services Required:		Resources Available:	
<input type="checkbox"/>	Other Identified Medical Conditions: _____		
<input type="checkbox"/>	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.		
<input type="checkbox"/>	GUARDED PROGNOSIS: Genetic/Family		
	Background Factors: *		
<input type="checkbox"/>	Mental/emotional disability/condition of parent:		Who Diagnosed?
<input type="checkbox"/>	Physical Condition/disability of parent:		Who Diagnosed?
<input type="checkbox"/>	Fetal alcohol spectrum disorder		Who Diagnosed?
<input type="checkbox"/>	Failure to Thrive (currently developmentally on target)		Who Diagnosed?
<input type="checkbox"/>	Multiple Placement Disruptions	Number of Placements	Types of Placements:
<input type="checkbox"/>	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:			
<input type="checkbox"/>	Basic Child Assessment	<input type="checkbox"/>	Adoption Staffing Report
<input type="checkbox"/>	Family Budget, if separate	<input type="checkbox"/>	Medical Statement
<input type="checkbox"/>	I.E.P.	<input type="checkbox"/>	Recruitment Plan
<input type="checkbox"/>		<input type="checkbox"/>	Adoptive Home Study
<input type="checkbox"/>		<input type="checkbox"/>	Psychologist/Psychiatrist Report
<input type="checkbox"/>		<input type="checkbox"/>	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