

# ELIGIBILITY FOR ADOPTION ASSISTANCE

Child's Name \_\_\_\_\_ DOB: \_\_\_\_\_ Client ID: \_\_\_\_\_

## Section A: Establish Eligibility for Adoption Assistance (Reference PPM Section 6210)

1. Is child legally free for adoption and in the custody of the Secretary of Kansas Department for Children and Families (DCF) or is a private adoption and in the custody of a licensed child-placing agency?  Yes  No

2. Is documentation present showing the child cannot or should not return home?  Yes  No  
(Attach all documentation used to determine that the child cannot return home.)

	Parent 1	Parent 2
Journal entry documenting the termination of both parental rights (TPR); or,	<input type="checkbox"/>	<input type="checkbox"/>
Journal entry documenting the child cannot return home; or,	<input type="checkbox"/>	<input type="checkbox"/>
Relinquishment by both parents to DCF or private agency, in lieu of TPR; or	<input type="checkbox"/>	<input type="checkbox"/>
Relinquishment by both parents to a private agency.	<input type="checkbox"/>	<input type="checkbox"/>

Parent deceased – date of death: \_\_\_\_\_

3. Does the child have one or more of the following specific factors or conditions?  Yes  No  
(Linking one or more factors to the need for assistance)

	Primary (choose one)	Others
a. Physical Disability	<input type="checkbox"/>	<input type="checkbox"/>
b. Developmental Disability	<input type="checkbox"/>	<input type="checkbox"/>
c. Behavior/Emotional Disability	<input type="checkbox"/>	<input type="checkbox"/>
d. Age of child _____	<input type="checkbox"/>	<input type="checkbox"/>
e. Member of a sibling group of three or more placed together	<input type="checkbox"/>	<input type="checkbox"/>
f. Two siblings placed together – other sibling has a specific factor	<input type="checkbox"/>	<input type="checkbox"/>
g. Guarded prognosis – no current symptoms	<input type="checkbox"/>	<input type="checkbox"/>
h. Other medical condition _____	<input type="checkbox"/>	<input type="checkbox"/>

Notes/Comments: \_\_\_\_\_

4. Were reasonable but unsuccessful efforts made to place without adoption assistance?  Yes  No  
(Mark all that apply. At least 1 marked box shows reasonable efforts were made.)

- This criterion is not applicable for the child being adopted by a relative or a foster family with whom the child has a significant relationship.
- Referrals of the child were made to state and national adoption exchanges.
- An individual recruitment plan was developed for this child.
- Special recruitment initiatives, such as TV or newspaper, were made for this child.
- The selected family cannot adopt without assistance.

Child's Name \_\_\_\_\_

DOB: \_\_\_\_\_

Client ID: \_\_\_\_\_

**Section A Results: Does the child qualify for adoption assistance?** (all 'yes' answers above)  Yes  No

*The answers to all questions above MUST be yes to meet the criteria for special needs determination.*

**Section B-1: Determine Basic/Admin Funding** (Reference PPM Section 6220)

1. Was child Title IV-E basic eligible in foster care?  Yes (possible FDFD; continue)  No (continue)
2. Was child eligible for SSI prior to the finalization of adoption?  Yes (possible FDFD; continue)  No (continue)
3. Is the child's parent a minor who meets IV-E cost of care criteria?  Yes (possible FDFD; continue)  No (continue)
4. Was child Title IV-E eligible in a prior adoption which dissolved?  Yes (possible FDFD; go to B.2)  No (continue)
5. Does child meet all conditions (a,b,c) below for fostering connections?  Yes (possible FDFD; go to B.2)  No (fund STST)
  - a. Child meets citizenship guidelines.  Check if True
  - b. FC court order contains 'contrary to the welfare' language.  Check if True
  - c. Child meets the age criteria.  Check if True

**Section B-2: Determine Payment/Maintenance Funding** (Reference PPM Section 6220)

1. Did adoptive parents agree to be fingerprinted and pass felony conviction criterion?  Yes (continue)  No (fund STST)
2. Is the child attending school?  N/A (continue)  Yes (continue)  No (fund STST)

**Basic/Admin Funding Determination**

Determined by: \_\_\_\_\_

Region: \_\_\_\_\_

\_\_\_\_\_  
 CPS Specialist/Designee Signature

\_\_\_\_\_  
 Date

\_\_\_\_\_  
 Supervisor's Signature

\_\_\_\_\_  
 Date

(To be completed by Eligibility Specialist)

Placement Agreement Signed: \_\_\_\_\_

Adoption Assistance Signed: \_\_\_\_\_

Adoption Assistance Effective: \_\_\_\_\_

Adoption Assistance Funding: FOCA/ASPD

All supporting documentation for eligibility must be in the Adoption Assistance Eligibility file.