

# APPLICATION FOR ADOPTION ASSISTANCE

## PRIVATE AGENCY PLACEMENTS

<b>Date of Application:</b>	<b>Type of Assistance Requested:</b>	
	<input type="checkbox"/> Medical	<input type="checkbox"/> Special Service
	<input type="checkbox"/> Monthly Assistance	<input type="checkbox"/> Nonrecurring

### I. Child Information:

Birth Name: \_\_\_\_\_ Adoptive Name: \_\_\_\_\_

\_\_\_\_\_ *Last*      *MI*      *First*      \_\_\_\_\_ *Last*      *MI*      *First*

Date of Birth *(attach birth verification):* \_\_\_\_\_ Place of Birth: \_\_\_\_\_

Child's Social Security Number *(Attach Card):* \_\_\_\_\_ Date of Application for Social Security Card: \_\_\_\_\_

Date of Custody to Private Agency: \_\_\_\_\_ Date of Judicial Determination *(attach journal entry):* \_\_\_\_\_

Date of Adoptive Placement \_\_\_\_\_ Date Petition Filed: \_\_\_\_\_

Date Adoption to be Finalized \_\_\_\_\_ County of Filing \_\_\_\_\_

### II. Special Needs of Child:

**B. Has application for SSI been made?**       Yes       No

*Date of application:* \_\_\_\_\_

Provide Description of physical, mental or emotional disability of child *(attach documentation):*

\_\_\_\_\_

### III. Birth Parent Information at Time of Relinquishment

Birth parents are:     Living Together     Living Apart

**Mother's Name:** \_\_\_\_\_ Date of Birth: \_\_\_\_\_

\_\_\_\_\_ *Last*      *MI*      *First*      Telephone No. \_\_\_\_\_

\_\_\_\_\_ Social Security No. \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_ *City*      \_\_\_\_\_ *State*      \_\_\_\_\_ *Zip*

Employer: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_ *City*      \_\_\_\_\_ *State*      \_\_\_\_\_ *Zip*

**Father's Name:**

Date of Birth: \_\_\_\_\_

Telephone No. \_\_\_\_\_

Social Security No. \_\_\_\_\_

\_\_\_\_\_  
Last

\_\_\_\_\_  
MI

\_\_\_\_\_  
First

Address: \_\_\_\_\_

\_\_\_\_\_  
City

\_\_\_\_\_  
State

\_\_\_\_\_  
Zip

Employer: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_  
City

\_\_\_\_\_  
State

\_\_\_\_\_  
Zip

Amount of Income in Home of Removal:(Mother; Mother and Father) \$ \_\_\_\_\_ Source of Income: \_\_\_\_\_

Did mother receive public assistance?  Yes  No Type of Assistance: \_\_\_\_\_

Is either parent disabled or deceased?  Yes  No If yes, are benefits received?  Yes  No

#### **IV. Birth Parent Information at Judicial Determination**

Living Together

Living Apart

**Mother's Name:**

Date of Birth: \_\_\_\_\_

Telephone No. \_\_\_\_\_

Social Security No. \_\_\_\_\_

\_\_\_\_\_  
Last

\_\_\_\_\_  
MI

\_\_\_\_\_  
First

Address: \_\_\_\_\_

\_\_\_\_\_  
City

\_\_\_\_\_  
State

\_\_\_\_\_  
Zip

Employer: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_  
City

\_\_\_\_\_  
State

\_\_\_\_\_  
Zip

**Father's Name:**

Date of Birth: \_\_\_\_\_

Telephone No. \_\_\_\_\_

Social Security No. \_\_\_\_\_

\_\_\_\_\_  
Last

\_\_\_\_\_  
MI

\_\_\_\_\_  
First

Address: \_\_\_\_\_

\_\_\_\_\_  
City

\_\_\_\_\_  
State

\_\_\_\_\_  
Zip

Employer: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_  
City

\_\_\_\_\_  
State

\_\_\_\_\_  
Zip

Amount of Income in Home of Removal:(Mother; Mother and Father) \$ \_\_\_\_\_ Source of Income: \_\_\_\_\_

Did mother receive public assistance?  Yes  No Type of Assistance: \_\_\_\_\_

Is either parent disabled or deceased?  Yes  No If yes, are benefits received?  Yes  No

#### **V. Adoptive Parents**

Phone No. ( Work): \_\_\_\_\_ Phone No. ( Home): \_\_\_\_\_

**Father's Name:**

**Mother's Name:**

\_\_\_\_\_  
*Last MI First*

\_\_\_\_\_  
*Last MI First*

Address: \_\_\_\_\_

\_\_\_\_\_  
City

\_\_\_\_\_  
State

\_\_\_\_\_  
Zip

**Father's Soc. Sec No.** \_\_\_\_\_

**Mother's Soc. Sec. No.** \_\_\_\_\_

Employer: \_\_\_\_\_

Employer: \_\_\_\_\_

Address: \_\_\_\_\_

Address: \_\_\_\_\_

Income: \$ \_\_\_\_\_

Income: \$ \_\_\_\_\_

Health Insurance: \_\_\_\_\_

Name of Primary Care  
Physician, if applicable: \_\_\_\_\_

Policy Holder: \_\_\_\_\_

\_\_\_\_\_  
Address

\_\_\_\_\_  
County

\_\_\_\_\_  
State

\_\_\_\_\_  
Zip

Insured: \_\_\_\_\_ Group/Policy # \_\_\_\_\_

Type of coverage: medical / dental / mental health/other: \_\_\_\_\_

**Attach copy of Insurance card.**

### **VI. Efforts to Place Without Adoption Assistance:**

Please describe efforts made by the agency to place without adoption assistance or the basis for the selection of this family as the best resource for the child. Separate page may be attached.

Include: Number of families offered the child; specialized recruiting efforts; referral to adoption exchanges, etc. Provide copy of adoptive home study and all supporting documents and reports.

Information submitted by: \_\_\_\_\_ Date: \_\_\_\_\_

Name of Agency: \_\_\_\_\_ Phone No.: \_\_\_\_\_

Date of Submission: \_\_\_\_\_

Signature

Information has been reviewed, and an eligibility determination has been complete.

The child  **is eligible**  **is not eligible** (check one)  
for adoption assistance based on: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

If the child is eligible, the family is to be contacted to negotiate the agreement. If the child is not eligible, the family should be notified in writing of the denial, the basis for the denial and advising them of their right to appeal. Copies of the notices should be sent to the private agency, a copy placed in the agency file and a copy given to the applicant.