

ADOPTION ASSISTANCE PROGRAM (AAP) AGREEMENT

NOTICE: This agreement describes the adoption assistance benefit that you will receive for your adopted child. If you agree, please sign the agreement and return it to the adoption agency. If you disagree, please contact the adoption agency. If you and the agency cannot reach an agreement, you will receive a Notice of Action which explains how to ask for a state hearing to resolve the matter.

I/We, _____ and _____, have entered into an agreement with the _____ for an adoption assistance benefit for _____.

(NAME OF PARENT)

(NAME OF PARENT)

(NAME, ADDRESS, TELEPHONE NUMBER OF AGENCY)

(NAME OF CHILD)

AAP eligibility is expected to continue from _____ until _____. This AAP Agreement will continue until it is modified or terminated in accordance with its terms.

(DATE OF ADOPTIVE PLACEMENT)

(EXPECTED ENDING DATE OF ELIGIBILITY)

- This is (check one) a deferred agreement (complete Section II only.)
- an initial agreement
- an amendment to the agreement dated _____.

(DATE OF INITIAL AGREEMENT)

Complete Section I or II as appropriate.

SECTION I

1. An AAP benefit of \$ _____ per month is authorized to begin _____. The child's needs must be reassessed periodically, at least every two years. The first scheduled reassessment is _____.
2. Unless the benefit is ending because of age, _____ will send me/us a Reassessment Information - Adoption Assistance Program (AAP 3) form at least 60 days before the next reassessment date. I/We shall complete the AAP 3 and return it to the _____.
3. With my/our agreement, the adoption agency in accordance with state law may increase or decrease the amount of the AAP benefit as my/our circumstances or the needs of the child change.
4. My child **may** be eligible for an age-related increase after his or her 5th, 9th, 12th and 15th birthdays. In Marin County, the age related increase occurs after his or her 5th, 7th, 9th, 12th, 13th and 15th birthdays. I/We **shall** contact the adoption agency to request this increase.
5. The AAP benefit may not exceed the age-related, state-approved foster family home care rate, and any applicable state-approved specialized care increment, which would have been paid if the child had not been placed for adoption.
6. The foster care payment that the child would have received may change if other income is received by or on behalf of the child. Any specialized care increment that the child would have received may change because of a change in his or her special needs. If the amount of the AAP benefit exceeds the foster care payment amount that the child would have received if he or she were in foster care, the AAP benefit will be reduced to that amount.

(BEGINNING DATE OF PAYMENT)

(FIRST REASSESSMENT DATE)

(COUNTY WELFARE DEPARTMENT)

(ADOPTION AGENCY)

7. If the child is currently a consumer of California Regional Center (CRC) services, the maximum available AAP benefit is \$3,006.00. CRC consumers who have received an AAP benefit which prior to July, 2007, exceeded \$3,006.00 may continue to receive the higher rate until such time the child is no longer eligible for AAP benefits.
8. Continuation of the AAP benefit depends upon my/our legal responsibility for the support of the child and on continued receipt of that support by the child.
9. I/We agree to inform the adoption agency immediately if any of the following occurs:
 - Our mailing address changes.
 - The child leaves the family home and we are no longer supporting the child.
 - We are no longer legally responsible for the support of the child.
 - The child begins to receive unearned income (*i.e.*, Social Security, SSI/SSP, other).
10. Failure to report these changes may result in an overpayment which may be recovered by a direct charge or a reduction in current and future AAP benefits.
11. I/We understand that _____ will remain eligible to receive an AAP benefit from the State of California regardless of the state in which I/we reside.
(NAME OF CHILD)
12. I/We understand that under the terms of this agreement the child is eligible for services under Title XIX (*Medicaid*) and Title XX (*Social Services*) of the Federal Social Security Act. _____ will help the child obtain these services by providing information and referral services if I/we live in or move to another state.
(ADOPTION AGENCY)
13. I/We understand that the child will not be eligible to receive an AAP benefit after he or she reaches the age of 18 years **unless** he or she has a mental or physical disability which warrants continuation of the benefit to the age of 21 years.

SECTION II (*Deferred Agreement*)

I/We understand that _____ has _____ which may result in a future need for an AAP benefit. Although assistance is not needed at this time, I/we understand that after completion of the adoption, if I am/we are unable to meet the child's needs related to this known medical condition, or physical, mental, emotional disability or other health condition, I/we may request an AAP benefit.
(NAME OF CHILD) (SPECIFY HEALTH PROBLEM)

REASONS FOR AAP ELIGIBILITY:

- Age
 Sibling Group Member
 Adverse Parental Background
 Minority Ethnicity
 Mental/Physical Health Problem

ADOPTIVE PARENT	DATE	ADOPTIVE PARENT	DATE
CHILD'S AGENCY REPRESENTATIVE	DATE	CHILD'S AGENCY NAME	
FAMILY'S AGENCY REPRESENTATIVE (CO-OP PLACEMENT ONLY)	DATE	FAMILY'S AGENCY NAME	