DEPARTMENT OF SOCIAL SERVICES
744 P Street, Sacramento, CA 95814

December 1, 1999

REASON FOR TRANSMITTAL
( ) State Law Change
( ) Federal Law or Regulation Change
(x) Court Order or Settlement Agreement
( ) Clarification Requested by One or More Counties
( ) Initiated by CDSS

ALL-COUNTY LETTER NO. 99-101

TO: ALL COUNTY WELFARE DIRECTORS
ALL PUBLIC ADOPTION AGENCIES
ALL CDSS ADOPTIONS DISTRICT OFFICES
ALL PRIVATE ADOPTION AGENCIES

SUBJECT: MARK A., et al. v. GRAY DAVIS, RITA SAENZ, AND CALIFORNIA DEPARTMENT OF SOCIAL SERVICES

The purpose of this letter is to notify you of the settlement in Mark A. et al. v. Davis (United States District Court, Eastern District of California, Case No. CIV-S-98-0041 LKK DAD). The settlement reached by the California Department of Social Services (CDSS), the plaintiffs, and the United States Department of Health and Human Services affects the manner in which the Adoption Assistance Program (AAP) is administered in California.

According to the terms of the settlement, the Department will immediately:

1. Cease requiring the use of the statewide median income guideline to determine AAP eligibility and payment amounts.

2. Cease requiring the production of evidence of income and expenses as a condition of receiving AAP benefits upon initial application or as part of the recertification process.

3. Cease requiring the reduction of AAP payments without the agreement of the adoptive parents for any reason other than (a) the child's ineligibility because of age, (b) the parents no longer being legally responsible for, or providing support to, the child; or, (c) the AAP payment amount exceeding the amount which would have been paid for the child in a foster family home.

4. Cease requiring prospective adoptive families to be informed that eligibility for adoption assistance is based on the income and financial resources of the adoptive parents.

CHANGES IN AAP POLICY AND PROCEDURES

This letter is your notification that the aforementioned AAP application and recertification procedures as prescribed in state regulations are no longer applicable. Instead, all applications and recertifications for AAP benefits shall be processed as follows:

1. There shall be no means test used to determine an adoptive family's benefits under the AAP, including the use of the statewide median income to determine payment amounts.

2. The amount of an adoption assistance cash benefit, if any, shall be a negotiated amount based upon the needs of the child and the circumstances of the family.

   "Circumstances of the family" means “the family's ability to incorporate the child into the household in relation to the lifestyle, standard of living, and future plans and to the overall capacity to meet the immediate and future needs, including education, of the child."

   For purposes of negotiating the amount of AAP benefits, agencies and CDSS Adoptions district offices should be guided by the legislative intent expressed in statutes governing the program. Welfare and Institutions Code Section 16115.5, in relevant part, states: "It is the intent of the Legislature in enacting this chapter to benefit children residing in foster homes by providing the stability and security of permanent homes, and in so doing, achieve a reduction in foster home care.” Counties and district offices are thus encouraged to keep in mind the ultimate goal of facilitating the adoption of a child when they negotiate with families, as long as the negotiated amount of benefits does not exceed the amount of foster care maintenance that the child would receive in a foster family home. Similarly, at the point of periodic recertification, any renegotiations of AAP benefits should be based on the child’s current needs, again with the amount of benefits limited to what the county would have otherwise authorized as a foster care maintenance payment for the child.

3. After an AAP agreement has been signed, the adoptive parents will continue to receive benefits in the agreed upon amount unless one of the following occurs:

   - The adoptive parents are no longer legally responsible for the support of the child.
   - The child is no longer receiving support from the adoptive family.
   - The adoption assistance payment exceeds the amount that the child would have been eligible for in a foster family home.
   - The adoptive parents demonstrate a need for an increased payment.
   - The adoptive parents voluntarily agree to reduce or terminate payments.

- The adopted child has an extraordinary need that was not anticipated at the time the amount of the adoption assistance was originally negotiated.

4. Upon request, all families shall have their current AAP benefits reassessed consistent with the requirements set forth in Paragraphs 1, 2, and 3 above.

5. Pending the Department's issuance of new AAP forms, agencies may continue to use the old forms but must not use any questions that are inconsistent with paragraphs 1-4 above. Agencies should cease using and delete the numbered sections of the AAP 1, AAP3, and AD 4320 as follows:

AAP 1 "Request for Adoption Assistance":

- Retain Item 1.
- Delete the itemized categories under Item 2a EXCEPT retain "Parents' total income."
- Delete "Attach a copy of your most recent federal income tax return.".
- Retain Item 2b.
- Delete Item 2c.
- Retain Item 2d.
- Retain Item 3 EXCEPT delete "unusual" (appears twice) and "that are unusually high" at Item 3d.
- Retain Items 4, 5, and 6.

AAP 3 "Recertification Information Adoption Assistance Program":

Page 1:

- ADD a box and "No Change" in the space above Item 1.

Page 2:

- Delete the itemized categories under Item 5a EXCEPT retain "Parents' total income."
- Delete "Attach a copy of your most recent federal income tax return.".
- Retain Item 5b.
- Delete Item 5c.
- Retain Item 5d.
- Retain Item 6 EXCEPT delete "unusual" (appears twice) and "that are unusually high" at Item 6d.
- Retain Items 7, 8, and 9.

AD 4320 "Adoption Assistance Agreement":

Page 1-Section 1:

- Delete Item 2.

Page 2:

- In Item 7, delete the items "Our financial circumstances change.", "The child's needs change.", and "The services for which payment have been authorized stop or change.".
- In Item 8, delete the first sentence "I/We and the agency will reevaluate and, if appropriate, adjust the amount of assistance if any of the above changes occur."

Attached are copies of these forms on which the above -referenced changes are indicated.

When instructing families in the completion of these forms, emphasis should be placed on ensuring that the families include their expenses throughout the year and not just the month the forms are completed.

NOTICE TO FAMILIES

Counties must immediately send written notification of the changes in the AAP made pursuant to the terms of the Mark A. settlement to all families who have received a notice of action since January 1, 1998, regarding an AAP application or recertification. Attached is a copy of the notice to be sent no later than March 1, 2000.

ADDITIONAL REQUIREMENTS

Under the terms of the settlement in Mark A., the CDSS is also required to:

- Develop emergency regulations implementing AB 390, Chapter 547, Statutes of 1999. (Department forms reflecting the changes in regulations will also be developed.)

- Develop and deliver by December 31, 2000, training for all county adoption agencies on the changes in the administration of the AAP due to the settlement and the enactment of AB 390, Chapter 547, Statutes of 1999.

- Develop, and/or update, and distribute a statewide publication that will describe the AAP and incorporate the requirements set forth in the settlement.

The CDSS will provide notification when each of these additional requirements is satisfied. County welfare departments and CDSS Adoptions district offices should distribute copies of this all-county letter to each unit providing adoption services to court dependent children.

Please take all necessary action now to ensure that your adoption agency or district office is complying with the requirements outlined in this all-county letter. If you have any questions regarding this matter, please contact the Adoptions Policy Bureau at (916) 322-4228.

Original Signed on 12/1/99
By Wesley A. Beers

WESLEY A. BEERS
Acting Deputy Director
Children and Family Services

Attachment

c: CWDA

Date

Name
Address
City, State

Dear :

This letter is to notify you that the United States District Court (Eastern District of California) has issued an order approving the settlement signed by the California Department of Social Services (CDSS), the plaintiffs, and the United States Department of Health and Human Services in Mark A., et al, v. Davis (CIV-S-98-0041 LKK DAD). The terms of the settlement affect the manner in which the CDSS administers the Adoption Assistance Program (AAP) in California.

All families who, after January 1, 1998, received a notice of action regarding an application or recertification for AAP benefits are being notified of the AAP changes resulting from the terms of the settlement. You are now entitled to have your child's AAP eligibility or benefits reassessed based on the terms of the settlement.

The terms of the settlement are as follows:

- There shall be no means test used to determine an adoptive family's benefits under the AAP, including the use of the statewide median income to determine payment amounts.

- The amount of an adoption assistance cash benefit, if any, shall be a negotiated amount based upon the needs of the child and the circumstances of the family.

  "Circumstances of the family" means “the family's ability to incorporate the child into the household in relation to the lifestyle, standard of living, and future plans and to the overall capacity to meet the immediate and future needs, including education, of the child."

- After an AAP agreement has been signed, the adoptive parents will continue to receive benefits in the agreed upon amount unless one of the following occurs:

    1. The adoptive parents are no longer legally responsible for the support of the child.

    2. The child is no longer receiving support from the adoptive family.

    3. The adoption assistance payment exceeds the amount that the child would have been eligible for in a foster family home.

    4. The adoptive parents demonstrate a need for an increased payment.

    5. The adoptive parents voluntarily agree to reduce or terminate payments.

    6. The adopted child has an extraordinary need that was not anticipated at the time the amount of the adoption assistance was originally negotiated.

- Upon request, all families receiving this notice have the right to have their current status regarding AAP eligibility or benefits reassessed consistent with the aforementioned changes in AAP policy and procedure.

If you believe your application or recertification for AAP eligibility or benefits should be reassessed based on the terms described in this notice, please contact:

County
Department
Address
City, State
Contact Person:
Telephone Number:

Sincerely,

Name
Title

REQUEST FOR ADOPTION ASSISTANCE

I/We, _____ (NAME OF FATHER) and _____ (NAME OF MOTHER), am/are considering adopting _____ (NAME OF CHILD), born _____ (DATE OF BIRTH). My/Our circumstances and the child's needs are such that I/we will require financial and/or medical assistance under the Adoption Assistance Program in order to agree to adopt this child.

Check (✓) one of the following:

☐ I/We do not require assistance at this time, but wish to complete an agreement with the agency which shall permit such assistance at a later time, due to the child's known medical condition or physical, mental or emotional handicap, or other health condition.

☐ After the child is placed for adoption, I/we will require assistance in meeting his or her needs for: _____

_____

_____.

I am/We are providing the following information to assist the agency in determining whether assistance may be provided, and in what amount. I/We understand that for assistance to be provided, the agency and I/we must agree on the amount, timing and duration of the assistance.

1. The number of persons in the household dependent on my/our support, including the child(ren) to be adopted ..... _____

2. **FAMILY INCOME:** Monthly / Annual

a. Adoptive parents' monthly income

Gross earnings from employment .....$ _____

Net income from self-employment .....$ _____

Dividends, interest, rent, etc. .....$ _____

Social Security, AFDC-FG/U, SSI and similar income .....$ _____

Parents' total income .....$ _____ X12 = $ _____

~~Attach a copy of your most recent federal income tax return.~~

b. **This child's** unearned income

Social Security .....$ _____

SSI/SSP .....$ _____

Other .....$ _____

This child's total income .....$ _____ X12 = $ _____

c. Unearned income of **other children** in family

Child's name:	_____	_____	_____	_____
AAP	$ _____	$ _____	$ _____	$ _____
AFDC-FC	$ _____	$ _____	$ _____	$ _____
Social Security	$ _____	$ _____	$ _____	$ _____
SSI/SSP	$ _____	$ _____	$ _____	$ _____
Other	$ _____	$ _____	$ _____	$ _____
Total	$ _____	$ _____	$ _____	$ _____

Total other children's income .....$ _____ X12 = $ _____

d. Total annual family income: .....$ _____

3. **FAMILY EXPENSES**

a. Mandatory payroll deductions

Taxes .....$ _____

Health care .....$ _____

Retirement (Do not include voluntarily deferred income) .....$ _____

Total mandatory deductions .....$ _____ X12 = $ _____

b. Housing costs

Rent .....$ _____

Mortgage payments .....$ _____

Property taxes .....$ _____

Property insurance .....$ _____

Total housing costs .....$ _____ X12 = $ _____

c. Medical care

Health Insurance .....$ _____

Unreimbursed medical expenses .....$ _____

Total medical care costs .....$ _____ X12 = $ _____

d. Other ~~unusual~~ expenses or normal family expenses ~~that are unusually high~~ (describe)

_____

_____

Total ~~unusual~~ expenses .....$ _____ X12 = $ _____

4. **HEALTH INSURANCE**

Does the family have health insurance? .....Yes ☐ No ☐

If Yes, name of insurance plan: _____

Is the child to be covered by this insurance? .....Yes ☐ No ☐

If no, reason: _____

_____

5. **OTHER INFORMATION**

a. Is the child a Regional Center client? .....Yes ☐ No ☐

If Yes, which Regional Center: _____

b. Please provide any other information which should be considered in determining the amount of Adoption Assistance Program benefits required. (You may attach additional pages.)

_____

_____

6. **MONTHLY AMOUNT OF AAP BENEFITS REQUESTED, IF ANY:**

For basic care (food, clothing, shelter, etc.) .....$ _____

To meet other specific needs .....$ _____

List need and direct cost (less any insurance coverage):

_____

_____

SIGNATURE OF MOTHER ▶ _____

DATE

SIGNATURE OF FATHER ▶ _____

DATE

RECERTIFICATION INFORMATION
ADOPTION ASSISTANCE PROGRAM

CHILD'S NAME
CHILD'S DATE OF BIRTH
CHILD'S AAP PAYMENT CASE NUMBER
COUNTY

DUE DATE (15 DAYS AFTER DATE MAILED)

The purpose of this form is to provide the adoption agency with an update on your circumstances and the needs of the child for whom you are receiving Adoption Assistance Program (AAP) payments and Medi-Cal coverage. **Complete this form within two weeks**, attaching extra sheets if necessary, and send it to:

NAME OF ADOPTION AGENCY
ADDRESS
TELEPHONE ( )

Check (✓) one of the following:

☐ I/We no longer wish to receive AAP payments and/or Medi-Cal coverage for the above-named child. If the need for benefits arises again, I/We may contact the adoption agency at that time.

☐ I/We continue to need AAP benefits for the above-named child and are providing the following information to assist the agency in determining whether or not assistance shall continue, and, if so, in what amount. I/We understand that failure to complete and return this form within two weeks (14 days) of the date it was mailed to me/us may cause interruption or delay of AAP benefits. If this form is not returned to the adoption agency by the date recertification is due, the agency will determine that benefits are no longer required and AAP payments and Medi-Cal coverage will stop.

☐ No Change

1. Our address is: _____

_____

Our telephone is: ( ) _____

2. *Check (✓) one of the following:*

☐ The child is living with us **-or-**

☐ The child is living with: _____

at: _____

_____

3. I/we require assistance in meeting the child's needs for: (Include known costs of meeting specific needs).

_____

_____

_____

4. The number of persons in the household dependent on my/our support, including myself and the child to be adopted, is _____.

(Continued on Reverse)

5. FAMILY INCOME:

	Monthly	Annual
a. Adoptive parents' monthly income		
Gross earnings from employment ....$		
Net income from self-employment.....$		
Dividends, interest, rent, etc.....$		
Social Security, AFDC-FG/U, SSI and similar income .....$		
Parents total income.....$	0.00	X12 = $

~~Attach a copy of your most recent federal income tax return~~.

b. This child's unearned income

AAP .....$		
Social Security.....$		
SSI/SSP .....$		
Other .....$		
This child's total income .....$	0.00	X12 = $

c. Unearned income of other children in family

Child's name:				
AAP	$	$	$	$
AFDC-FC	$	$	$	$
Social Security	$	$	$	$
SSI/SSP	$	$	$	$
Other	$	$	$	$
Total	$ 0.00	$ 0.00	$ 0.00	$ 0.00
Total other children's income .....$	0.00	X12 = $		

d. Total annual family income:.....$ 0.00

6. FAMILY EXPENSES

a. Mandatory payroll deductions		
Taxes.....$		
Health care .....$		
Retirement (Do not include voluntarily deferred income) .....$		
Total mandatory deductions.....$	0.00	X12 = $
b. Housing costs		
Rent.....$		
Mortgage payments.....$		
Property taxes .....$		
Property insurance .....$		
Total housing costs .....$	0.00	X12 = $
c. Medical care		
Health Insurance .....$		
Unreimbursed medical expenses.....$		
Total medical care costs.....$	0.00	X12 = $

d. Other ~~unusual~~ expenses or normal family expenses ~~that are unusually high~~ (describe)

Total ~~unusual~~ expenses .....$ 0.00 X12 = $

7. HEALTH INSURANCE

Does the family have health insurance? .....Yes ☐ No ☐

If Yes, name of insurance plan:

Is the child covered by this insurance? .....Yes ☐ No ☐

If no, reason:

8. OTHER INFORMATION

a. Is the child a Regional Center client?.....Yes ☐ No ☐

If Yes, which Regional Center:

b. Please provide any other information which should be considered in determining the amount of Adoption Assistance Program benefits required.

9. MONTHLY AMOUNT OF AAP BENEFITS REQUESTED, IF ANY:

For basic care (food, clothing, shelter, etc.).....$

To meet other specific needs.....$

List need and direct cost (less any insurance coverage):

SIGNATURE OF MOTHER ▶

DATE

SIGNATURE OF FATHER ▶

DATE

ADOPTION ASSISTANCE AGREEMENT

DISTRIBUTION:
Original: Adoptive Applicants
Copy: Agency file

NOTICE: *This agreement describes the adoption assistance benefits you will receive for your adopted child. If you agree, you should sign the agreement on the back 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
(NAME OF PARENT) (NAME OF PARENT)

agreement with the_____for
(NAME, ADDRESS, TELEPHONE NUMBER OF AGENCY)

adoption assistance for_____.
(NAME OF CHILD)

Under the terms of this agreement, Adoption Assistance Program eligibility is expected to continue

from_____until_____.
(DATE OF ADOPTIVE PLACEMENT) (EXPECTED ENDING DATE OF ELIGIBILITY - NOT DATE OF NEXT RECERTIFICATION)

This is (check one) ☐ a deferred agreement (complete Section II only) or ☐ an initial agreement or
☐ an amendment to the agreement dated_____.
(DATE OF INITIAL AGREEMENT)

Complete Section I or II as appropriate.

SECTION I

1. Adoption Assistance Program payment of $_____per month are authorized

   from_____until_____. The payments are being made to assist
   (BEGINNING DATE OF PAYMENT OR DATE OF CHANGE) (NEXT RECERTIFICATION DATE)

   me/us in meeting_____need for
   (NAME OF CHILD)

   _____
   (NEEDS TO BE MET BY ADOPTION ASSISTANCE PROGRAM)

   _____

   _____.

~~2. $_____of each monthly payment is for_____.~~
~~(SPECIFIC SERVICE(S))~~

~~This part of the payment will continue only until_____or when this service ends, whichever occurs first. I/We agree to this future reduction in benefits.~~

3. Unless payments are ending because of age,_____will send me/us a
   (COUNTY WELFARE DEPARTMENT)
   Recertification Information - Adoption Assistance Program form at least 60 days before the payments are scheduled to end.

   I/We will complete the form and return it to the _____. If I/we do not return
   (ADOPTION AGENCY)
   the Recertification Information form, the adoption agency will conclude that I/we no longer need Adoption Assistance Program benefits and benefits will stop until I/we make a new request for assistance and enter into a new Adoption Assistance Agreement.

4. With my/our agreement, the adoption agency may increase or decrease the amount of Adoption Assistance Program benefits as my/our circumstances or the needs of the child change.

5. However, payments may not exceed the foster care payment, based on the state-set, state-participation foster care rates, which would have been made if the child had not been placed for adoption. The foster care payment that the child would have received may be reduced because all foster care rates are reduced; any specialized care increment which he or she might have received is reduced because of a change in age or condition; or other income is received by or on behalf of the child. If the Adoption Assistance Program payment exceeds the new foster care payment that the child would have received, the Adoption Assistance Program payment will be reduced to the new foster care payment amount.

6. Continuation of adoption assistance payment depends upon my/our legal responsibility for the support of the child and on continued receipt of that support by the child.

7. I/We agree to inform the adoption agency immediately if any of the following events occur:
   — Our residence or our mailing address changes.
   — The child leaves the family home or we stop supporting the child.
   — ~~Our financial circumstances change~~.
   — ~~The child's needs change.~~
   — ~~The services for which payment have been authorized stop or change.~~

8. ~~I/We and the agency will reevaluate and, if appropriate, adjust the amount of assistance if any of the above changes occur.~~ Failure to report these changes could result in an overpayment which may be recovered by a direct charge or a reduction in current and future Adoption Assistance Program benefits.

9. I/We understand that this agreement shall remain in effect regardless of the state in which I/we reside.

10. I/We understand that under the terms of this agreement the child is eligible for services under Titles XIX (Medicaid) and XX (Social Services) of the Federal Social Security Act. _____ will help the
    (ADOPTION AGENCY)
    child obtain these services if I/we live in or move to another state by providing information and referral services.

11. I/We understand that the child will not be eligible to receive Adoption Assistance Program benefits after he or she reaches the age of 18 years unless he or she has a mental or physical handicap which warrants continuation of payment to the age of 21 years.

SECTION II

I/We understand that _____ has _____ which
(NAME OF CHILD) (SPECIFY HEALTH PROBLEM)
may result in a future need for Adoption Assistance Program benefits. 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 need related to this known medical condition, or physical, mental, emotional handicap or other health condition, I/we may request adoption Assistance Program benefits.

REASONS FOR ADOPTION ASSISTANCE PROGRAM ELIGIBILITY:

☐ Age ☐ Sibling Group Member ☐ Minority Ethnicity ☐ Mental/Physical Health Problem

CHILD'S AGENCY REPRESENTATIVE SIGNATURE	DATE	CHILD'S AGENCY NAME	
ADOPTIVE PARENT SIGNATURE	DATE	FAMILY'S AGENCY REPRESENTATIVE (COOPERATIVE PLACEMENT ONLY)	DATE
ADOPTIVE PARENT SIGNATURE	DATE	FAMILY'S AGENCY NAME	