

Kin-GAP MUTUAL AGREEMENT FOR 18 YEAR OLDS

CASE NAME
BIRTH DATE
CASE NUMBER

I request that the _____ County Welfare Department/Probation Department or _____ Tribe
 (circle appropriate public agency)

maintain my Kin-GAP payment until the completion of my education/training by age 19.

Recognizing my responsibility, I agree to:

1. Assist the responsible public agency in determining my financial need and eligibility while receiving a Kin-GAP payment.
2. Keep the responsible public agency informed of my progress with my education/training program.
3. Give reasonable notice if I leave my guardian's home for more than a temporary absence.

SIGNATURE OF Kin-GAP YOUTH		Kin-GAP YOUTH'S ELIGIBILITY WORKER	
ADDRESS		ADDRESS	
TELEPHONE ()	ALTERNATIVE TELEPHONE ()	TELEPHONE ()	
DATE		DATE	

STATEMENT OF FACTS SUPPORTING ELIGIBILITY FOR KINSHIP GUARDIANSHIP ASSISTANCE PAYMENT (Kin-GAP) PROGRAM: *The legal guardian should complete in ink all questions to the left of the heavy black line with information about the child for whom they are the legal guardian. If there are multiple children, one form per child should be completed. Please complete, sign and date this form within two weeks, attaching extra sheets if necessary. Failure to complete and return this form within two weeks (14 days) of the date it was mailed will cause interruption, termination or delay in your receipt of the benefit.*

① Child Name _____ ② Male Female

③ Address _____

④ Birth date _____ ⑤ Birthplace _____

⑥ Social Security # _____ Applied For? Yes No

⑦ Citizen of U.S.? Yes No ⑧ Alien Status: _____

⑨ Does the child have medical insurance other than Medi-Cal? Yes No

If yes, list policy number, company name, and name of policy: _____

⑩ Does the child have real or personal property? Yes No

If yes, list property type (land, cash, auto, motorcycle, life insurance, trust fund, bank account, bond, etc.) and its value: _____

⑪ Does the child have income? Yes No Unknown*

If yes, list amounts below. If application pending, check associated box.

INCOME TYPE	AMOUNT	PENDING
Social Security	\$ _____	
Child Support	\$ _____	
Railroad Retirement	\$ _____	
SSI/SSP	\$ _____	
Veteran's Benefits	\$ _____	
Salary/Wages	\$ _____	
Other (specify)	\$ _____	
Total Amount/Month	\$ _____	

*If unknown, please explain: _____

⑫ Does the child have siblings placed with you? Yes No

If yes, list the names and DOB.

NAME OF SIBLING	DATE OF BIRTH

⑬ Is the child's mother or father deceased? Yes No

⑭ Has the child's parents been receiving Social security or VA benefits? Yes No

If yes, explain and list amount if known: _____

⑮ If the youth is age 16 or older, does the youth want a referral to the ILP Program? Yes No

⑯ Does the child reside in your home? Yes No

If no, do you provide any support for the above-named child? Yes No

⑰ Does this youth have a child(ren) of his/her own residing in your home? Yes No

⑱ Do you have a shared responsibility plan about the care of the child with the minor parent? Yes No

⑲ Do you have guardianship of the child which was granted by a California juvenile court? Yes No

ELIGIBILITY WORKER ONLY

APPLICATION
 REASSESSMENT

CASE NAME _____

CASE NUMBER _____

VERIFICATION

AGE _____

SOCIAL SECURITY NUMBER _____

CITIZENSHIP/ALIEN STATUS _____

DHS 6155

CHILD'S PROPERTY _____

DOES THE CHILD HAVE SIBLINGS PLACED WITH THE GUARDIAN? _____

DID THE CHILD RESIDE FOR AT LEAST SIX CONSECUTIVE MONTHS IN THE APPROVED HOME OF THE PROSPECTIVE RELATIVE GUARDIAN? _____

SPECIAL NEEDS CHILDREN INFORMATION	VERIFICATION
<p>20) Does this child have special needs, i.e., health and/or behavior problems? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If yes, I am requesting an assessment of the child's special needs to determine if the specialized care increment meets the needs of this child.</p>	<p>ILP</p>
<p>COMPLETE BELOW FOR CHILDREN 18 AND OLDER</p>	<p>VERIFICATION BY SCHOOL YES</p> <p>SCHOOL ATTENDANCE <input type="checkbox"/></p> <p>GRADUATION</p>
<p>21) Expected graduation/completion before the 19th birthday? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>22) Do you request an assessment for continued payment over the age of 18 because the youth has a mental or physical handicap? If yes, describe condition: <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>23) Was guardianship ordered in a juvenile court after the youth's 16th birthday? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If yes, is youth participating in one of the following activities (Note: this provision does not apply until January 2, 2012):</p> <ul style="list-style-type: none"> <input type="checkbox"/> Completing secondary education (e.g., high school) or a program leading to an equivalent credential (e.g., taking classes in preparation for a general equivalency diploma exam). <input type="checkbox"/> Enrolled in an institution which provides post-secondary (e.g., university or college) or vocational education (e.g., trade school). <input type="checkbox"/> Participating in a program or activity designed to promote, or remove barriers to employment (e.g., enrolled in Job Corps or attending classes on resume writing and interview skills). <input type="checkbox"/> Employed for at least 80 hours per month. <input type="checkbox"/> Is incapable of doing any of the previously described educational or employment activities due to a documented medical condition. <input type="checkbox"/> None of the above. 	<p>GUARDIANSHIP VERIFIED</p> <p>CHILD SUPPORT REFERRAL BEST INTEREST DETERMINATION NOT TO REFER</p>
<p>LEGAL GUARDIAN: I DECLARE UNDER PENALTY OF PERJURY THAT THE FOREGOING STATEMENTS ARE TRUE AND CORRECT.</p> <p>_____ SIGNATURE OF LEGAL GUARDIAN</p>	<p><input type="checkbox"/> NOT ELIGIBLE</p> <p><input type="checkbox"/> ELIGIBLE</p> <p style="padding-left: 20px;"><input type="checkbox"/> FEDERAL</p> <p style="padding-left: 20px;"><input type="checkbox"/> NONFEDERAL</p> <p style="padding-left: 20px;"><input type="checkbox"/> OTHER</p>
<p>_____ COUNTY WHERE SIGNED</p> <p>_____ SIGNATURE OF ELIGIBILITY WORKER</p> <p>_____ SIGNATURE OF ELIGIBILITY WORKER SUPERVISOR</p>	<p>_____ DATE</p> <p>_____ DATE</p> <p>_____ DATE</p>

RELEASE OF INFORMATION

You and any member of your family for whom you are applying for aid must give us a Social Security Number(s) (SSN). The SSN(s) are needed to determine your eligibility. Failure to cooperate may result in denial or discontinuance of aid. Authority: **Welfare and Institutions Code, Section 11268.**

PERSONAL INFORMATION NOTICE

Pursuant to the Federal Privacy Act (P.L. 93-679) and the information Practices Act of 1977 (Civil Code Sections 1798, et. seq.), notice is hereby given for the request of personal information by this form. The requested personal information is voluntary. The principal purpose of the voluntary information is to facilitate the processing of this form. The failure to provide all or any part of the requested information may delay processing of this form. No disclosure of personal information will be made unless permissible under Article 6, Section 1798.17 of the IPA of 1977. Each individual has the right upon request and proper identification, to inspect all personal information in any record maintained on the individual by an identifying particular. Direct any inquiries on information maintenance to your IPA Forms Officer.

Kin-GAP MUTUAL AGREEMENT FOR NONMINOR FORMER DEPENDENTS

CASE NAME
BIRTH DATE
CASE NUMBER

I request that the _____ Child Welfare Services/Probation Department or
(circle appropriate public agency)
_____ Tribe maintain my extended Kin-GAP payment.

Recognizing my responsibility, I agree to:

1. Assist the responsible public agency in determining my financial need and eligibility while receiving a Kin-GAP payment.
2. Update/notify the responsible public agency and relative guardian if there are any changes in my circumstances or living arrangements.

Select criteria below:

3. I am over 18 years old and have a documented physical or mental disability that warrants continuation of Kin-GAP assistance until I am 21 years old pursuant to Welfare and Institutions Code (W&IC) sections 11363(c)(2) and 11386(g)(2).
4. I meet at least one of the five participating criteria as set forth in W&IC section 11403(b). I am (check all that apply):
 - Completing high school or an equivalency program.
 - Enrolled or enrolling in a post-secondary or vocational school.
 - Participating in a program or activity that promotes or removes barriers to employment.
 - Employed at least 80 hours per month.
 - Incapable of participating in 1-4 above, due to a documented physical or mental condition.
5. Keep the responsible public agency informed of my progress with my education/training program

SIGNATURE OF Kin-GAP YOUTH/AUTHORIZED REPRESENTATIVE		Kin-GAP YOUTH'S ELIGIBILITY WORKER
ADDRESS		ADDRESS
HOME TELEPHONE	ALTERNATE TELEPHONE	OFFICE TELEPHONE
DATE		DATE

AGENCY-RELATIVE GUARDIANSHIP DISCLOSURE

ONE COPY TO: Relative Caregiver
Child's Social Services Record
Child's Eligibility Record

NOTE: THIS DISCLOSURE MUST BE COMPLETED PRIOR TO A RELATIVE BECOMING LEGAL GUARDIAN

NAME OF CHILD:		CAREGIVER'S NAME:	
DATE PLACED WITH THIS RELATIVE:	DATE OF BIRTH:	SOCIAL SECURITY NUMBER:	

Initial Here:

- _____ I understand that I am not required to change custodial status from relative caregiver to legal guardian. However, if I decide to become a legal guardian, court dependency may be dismissed.
- _____ I have been provided a Guardianship Pamphlet.

**1. AFDC-Foster Care to Kin-GAP
Initial Here:**

_____ I understand that by becoming a relative legal guardian of _____:

- The child's payment will change from \$_____ to \$_____ per month.
- When the child reaches age 18 years, the child must complete the Kin-GAP Mutual Agreement for 18 year olds to continue to receive Kin-GAP payments until they reach the age of 19 years or completes their secondary education or vocational training prior to 19 years.
- The child may be eligible for continued benefits up to age 21 years if the child has a mental or physical disability. If you start to receive Kin-GAP benefits before the child's 16th birthday and the child does not have such a disability, the child will not be eligible for the up-to-age 21 extension of benefits that comes into effect as of January 1, 2012.
- The child will no longer be eligible to receive an AFDC-Foster Care payment.
- The child's siblings are eligible for Kin-GAP if they live in the same household.
- The child will be eligible to receive a clothing allowance and the state supplemental clothing allowance.
- The child may be eligible to receive a specialized care increment if already in receipt of a specialized care increment or may receive a specialized care increment if the needs of the child change in the future. Note: the amount of the specialized care increment may be increased or decreased based on changes to the child's special needs.
- If the child is a consumer of California regional center services, he/she will be eligible for a dual agency rate and may be eligible for a supplemental rate.
- Non-referral to child support may continue if the social worker determines it is in the best interest of the child. If not, the parent may have to pay child support to the agency.
- The child remains eligible for Independent Living Program services when the child attains age 16 and such services are requested by you the caregiver or the child. However the youth will not be eligible for the Chafee Educational/Training Voucher unless the youth remains in foster care until age 16 prior to the transfer to Kin-GAP.
- The Infant Supplement and the \$200 Shared Responsibility Plan increment may be payable in Kin-GAP.
- If I move to another county, the Kin-GAP rate paid to me will be based on the host county's rate, or the rate of the county which had court-ordered jurisdiction over the legal guardianship if it is determined that the host county rate cannot be paid.

- If I move out of state, the Kin-GAP payment may continue. In addition, if I remain eligible for a Kin-GAP payment, after moving out of state, I will be eligible for Medicaid based on that state's Medicaid program.
- If the child is eligible for Kin-GAP, he/she will also be eligible for Medi-Cal.
- The child's Kin-GAP and Medi-Cal eligibility may be impacted if resources exceed \$10,000 or residence is out of state.
- Any income, which the youth has earned as part of their transitional independent living plan, is exempt.
- The child will not be eligible for the Transitional Housing Program or the Transitional Housing Program Plus.

2. AFDC-FC to CalWORKs
Initial Here:

_____ I understand that by becoming a relative legal guardian of _____:

- The child's payment will change from \$_____ to \$_____ per month.
- The child will not receive an AFDC-Foster Care payment.
- The child will not receive a clothing allowance or a specialized care increment.
- The child will not be eligible for the Transitional Housing Program.

3. CalWORKs to Kin-GAP
Initial Here:

_____ I understand that by becoming a relative legal guardian of _____:

- The child's payment will change from \$_____ to \$_____ per month.
- The child's siblings are eligible for Kin-GAP if they live in the same household.
- The child cannot get both CalWORKs and Kin-GAP payments.
- The child will no longer be eligible to receive Cal-Learn benefits.
- The child will no longer be eligible to receive CalWORKs child care services.
- The child will be eligible to receive a clothing allowance and may be eligible to receive a specialized care increment if the needs of the child change in the future. Note: the amount of the specialized care increment may be increased or decreased based on changes to the child's special needs.
- If the child is a consumer of California regional center services, he/she will be eligible for a dual agency rate and may be eligible for a supplemental rate.
- Non-referral to child support may continue if the social worker determines it is in the best interest of the child. If not, the parent may have to pay child support to the agency.
- The child remains eligible for Independent Living Program services when the child attains age 16 and such services are requested by you the caregiver or the child. However, the youth will not be eligible for the Chafee Educational/Training Voucher unless the youth remains in foster care until age 16 prior to the transfer to Kin-GAP.

- When the child reaches age 18 years, the child must complete the Kin-GAP Mutual Agreement for 18 year olds to continue to receive Kin-GAP payments until they reach the age of 19 years or completes their secondary education or vocational training prior to 19 years.
- The child may be eligible for continued benefits up to age 21 years if the child has a mental or physical disability. If you start to receive Kin-GAP benefits before the child's 16th birthday and the child does not have such a disability, the child will not be eligible for the up-to-age 21 extension of benefits that comes into effect as of January 1, 2012.
- The Infant Supplemental and the \$200 Shared Responsibility Plan increment may be payable in Kin-GAP.
- If I move to another county, the Kin-GAP rate paid to me will be based on the host county's rate, or the rate of the county which had court-ordered jurisdiction over the legal guardianship if it is determined that the host county rate cannot be paid.
- If I move out of state, the Kin-GAP payment may continue. In addition, if I remain eligible for a Kin-GAP payment, after moving out of state, I may be eligible for Medicaid based on that state's Medicaid program.
- If the child is eligible for Kin-GAP, he/she will also be eligible for Medi-Cal.
- The child's Kin-Gap and Medi-Cal eligibility may be impacted if resources exceed \$10,000 or residence is out of state.
- Any income, which the youth has earned as part of their transitional independent living plan, is exempt.
- The child will not be eligible for the Transitional Housing Program or the Transitional Housing Program Plus.
- If the relative caregiver is on CalWORKs and is caring for one or more foster children and all children in the assistance unit move to Kin-GAP, the caregiver may continue to remain eligible for a CalWORKs grant as a family of one.

4. Remain CalWORKs
Initial Here:

_____ I understand that by becoming a relative legal guardian of _____:

- The child will not receive an AFDC-Foster Care or Kin-GAP payment.
- The child will remain eligible to CalWORKs.

Services

If you become guardian of this child and the court dependency is terminated:

Initial Here:

_____ I understand that I may receive assistance from the county child welfare agency if it is necessary to terminate guardianship or to appoint a co-guardian for the child.

_____ I understand that I may renegotiate the payment if my circumstances or the needs of the child change;

_____ I understand that the child and I will no longer be assigned a social worker;

_____ I understand that the child and I will no longer be required to go to court;

_____ I understand that the child will no longer have a court appointed attorney;

_____ I understand that I am not prevented from adopting this child at any time in the future;

_____ I understand that I may still contact the county if I need assistance at _____;

_____ Other: _____

Some Important Kin-GAP Information

These are some of the important things you should know about Kin-GAP:

Initial Here:

- _____ I understand that every two years I will be required to complete a review of the child's circumstances with the county. I understand that I must report within 5 days any changes which may affect the child's eligibility for the program.
- _____ I understand that if I move to another county/state, my payment will be based on the host county's/state's rate, or the rate of the county/state which had court-ordered jurisdiction over the legal guardianship if it is determined that the host county/state rate cannot be paid.
- _____ I understand that any specialized care increment that I receive may change based on the child's health or behavioral needs.

I have read the above and understand all of the legal guardianship options that are available to me (adoption, legal guardianship, long-term foster care). After considering all the options, I have voluntarily chosen legal guardianship with the associated payment noted above.

I have chose option # 1 2 3 4 (*Circle one*)

SIGNATURE OF SOCIAL WORKER: 		SIGNATURE OF RELATIVE LEGAL GUARDIAN: 	
TITLE/AGENCY:			
ADDRESS:		ADDRESS:	
TELEPHONE NUMBER ()	DATE:	TELEPHONE NUMBER ()	DATE:

RELEASE OF INFORMATION

You and any member of your family for whom you are applying for aid must give us a Social Security Number(s) (SSN). The SSN(s) are needed to determine your eligibility. Failure to provide SSN may result in denial or discontinuance of aid. Authority: **Welfare and Institutions Code, Section 11268.**

KINSHIP GUARDIANSHIP ASSISTANCE PAYMENT (KIN-GAP) PROGRAM AGREEMENT AMENDMENT

This form amends and supplements the SOC 369 to memorialize the terms, conditions, rights, responsibilities, and agreements reached between the county child welfare agency, probation department or Title IV-E agreement tribe and the relative guardian.

NOTICE: This agreement describes the guardianship assistance benefit that you will receive. If you agree, please sign the agreement and return it to the responsible public agency. If you disagree, please contact the responsible public agency. If you and the agency cannot reach an agreement, you will receive a Notice of Action which explains how to request a state hearing to resolve the matter.

I/We, _____ and _____, have
(NAME OF LEGAL GUARDIAN) (NAME OF LEGAL GUARDIAN)

entered into an agreement with the _____ for a
(NAME OF RESPONSIBLE PUBLIC AGENCY)

(check one) federally eligible;

state eligible

Kinship Guardianship Assistance Payment (Kin-GAP) for _____
(NAME OF CHILD)

This Kin-GAP Agreement will continue until it is modified or terminated in accordance with its terms.

This is (check one) an initial agreement

an amendment to the agreement dated _____
(DATE OF INITIAL AGREEMENT)

1. A Kin-GAP benefit of \$ _____ per month is authorized to begin _____
(BEGINNING DATE OF PAYMENT)

The child's needs must be reassessed at least every two years. The next scheduled reassessment is

(REASSESSMENT DATE)

2. Unless the benefit is ending because of age, _____ will send a Statement of Facts
(RESPONSIBLE PUBLIC AGENCY)

Supporting Eligibility for Kinship Guardianship Assistance Payment (Kin-GAP) Program (KG 2 form), at least 60 days before the next reassessment date. I/We shall complete the KG 2 and return it within 14 days to

_____. I/We understand that failure to complete and return this form in a timely
(RESPONSIBLE PUBLIC AGENCY)

manner may result in an interruption, delay or termination in the receipt of the benefit.

3. If applicable, any specialized care increment (SCI) that the child receives may change as the needs of the child change.
4. A child receiving Kin-GAP shall 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, 12th, 13th and 15th birthdays.)
5. The Kin-GAP benefit may not exceed the age-related, state-approved foster family home care rate, and any applicable state-approved SCI, that would have been paid if the child had remained in foster care.
6. The Kin-GAP payment that the child receives may change if other income is received by or on behalf of the child.
7. A child receiving Kin-GAP benefits may retain cash and other assets subject to limitations established by law.
8. A child receiving Kin-GAP shall be eligible for a clothing allowance in accordance with state law and as established by the county of legal responsibility.

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9. For a youth eligible for a Kin-GAP benefit who is a teen parent and has a child living in the same home, the rate may include a two hundred dollar (\$200) monthly payment made to the relative caregiver in a whole family foster home.
10. If a child is living with a teen parent who is eligible for Kin-GAP benefits, the rate paid to the relative guardian on behalf of the teen parent shall include the "infant supplement" which is an additional benefit for the care and supervision of the child.
11. Payments on behalf of a child who is a recipient of Kin-GAP benefits and who is also a consumer of a California regional center services shall be based on the dual agency rates established by the State Department of Social Services.
12. Continuation of the Kin-GAP benefit depends upon my/our responsibility for the support of the child and on the child's continued receipt of my/our support.
13. I/We agree to inform the agency immediately if any of the following occurs:
- Our address changes.
 - The youth is no longer residing in the family home.
 - I/We are no longer providing any type of support to the youth.
 - I/We are no longer responsible for the support of the youth.
 - Guardianship is terminated and/or dependency is reinstated.
 - The child begins to receive earned or unearned income (i.e., Social Security, SSI/SSP, other).
- Failure to report these changes may result in an overpayment which may be recovered by a one-time charge or a reduction in current and future Kin-GAP benefits.
14. I/We understand that _____ will remain eligible to receive a Kin-GAP benefit from the State of California regardless of where I/we reside.
(NAME OF CHILD)
15. I/We understand that under the terms of this agreement the child is eligible for medical services under Medi-Cal, California's Medicaid program. It is understood that if we move to another state we will need to apply for Medicaid in that state. I/We are aware that medical coverage and social services may vary in other states.
16. I/We understand that the child will not be eligible to receive a Kin-GAP payment after reaching the age of 18 years unless he or she is in school and is expected to graduate by the age of 19 years.
17. Effective January 1, 2012, a former dependent child or ward of the juvenile court who is eligible for the Kin-GAP program and who attained 16 years of age before originally entering the Kin-GAP program shall continue to receive aid up to 19 years of age; effective January 1, 2013, up to 20 years of age; and, effective January 1, 2014, up to 21 years of age [the extension of benefits for those between 20 and 21 years of age shall be contingent upon appropriation by the California Legislature], as long as one or more of the following conditions exist:
- (1) The individual is completing secondary education or a program leading to an equivalent credential.
 - (2) The individual is enrolled in an institution which provides postsecondary or vocational education.
 - (3) The individual is participating in a program or activity designed to promote or remove barriers to employment.
 - (4) The individual is employed for at least 80 hours per month.
 - (5) The individual is incapable of doing any of the activities described in (1) to (4), inclusive, due to a medical condition, and that incapability is supported by regularly updated information in the case plan of the individual.
18. Kin-GAP benefits shall continue to age 21 if the youth has a physical or mental disability that warrants the continuation of assistance.
- Pursuant to Welfare and Institutions Code Section 1403(c), relative guardians who receive Kin-GAP payments are responsible for reporting to the responsible public agency when the nonminor former dependent no longer satisfies at least one of the five conditions described above.

19. I/We understand that under the terms of this agreement the child is eligible for services which include assistance in the filing of a petition to appoint a co-guardian or a successor guardian for the child to have dependency jurisdiction resumed, or to terminate guardianship.
20. I/We will not be charged or have to pay any fees or costs to establish guardianship.
21. Once the youth attains the age of 16, he or she may request and receive independent living program services.
22. The youth, who was in foster care between the ages of 16 - 18 while under the care and custody of the juvenile court, is eligible to apply for a Chaffee Education and Training Voucher.
23. I/We acknowledge that a copy of this written agreement has been received.
24. I/We understand that reimbursement can be made for reasonable and verified nonrecurring expenses incurred from obtaining legal guardianship to the extent the expenses don't exceed \$2,000. Reimbursement shall not be made for costs otherwise reimbursed from other sources.
25. In the event of my death or incapacitation I/we would like _____ to become the successor guardian.
(NAME OF SUCCESSOR GUARDIAN)

I/We are in agreement with the provisions of this document.

I/We are not in agreement with the provisions of this document and request a state hearing.

LEGAL GUARDIAN	DATE	RESPONSIBLE PUBLIC AGENCY REPRESENTATIVE	DATE
LEGAL GUARDIAN	DATE	RESPONSIBLE PUBLIC AGENCY NAME, ADDRESS TELEPHONE NUMBER	

TO REQUEST A REASSESSMENT, GET HELP CONCERNING GUARDIANSHIP OR TO REQUEST SERVICES, PLEASE CALL OR WRITE THE PUBLIC AGENCY LISTED ABOVE.

**NOTICE AND AGREEMENT FOR
CHILD, SPOUSAL AND MEDICAL SUPPORT****Complete one form for each noncustodial
parent or alleged father.****Assignment and Cooperation Rules**

You must assign (give to) the county any rights you may have for:

- Any child or spousal support payments you get while receiving cash aid.
- Medical support you get while getting Medi-Cal.

The receipt of a cash aid payment and/or Medi-Cal Benefits Identification Card (BIC) will assign the past and present support rights of all persons for whom you are requesting cash aid and/or medical assistance. You will be sent facts on the amount of support the county gets from the noncustodial parent(s).

Cooperation

You must cooperate with the county and the Local Child Support Agency (LCSA) to:

- Identify and locate any noncustodial parent/alleged father in your case;
- Tell the county or LCSA any time you get facts about the noncustodial parent/alleged father, such as place of residence or work location;
- Agree to cooperate in the support enforcement process or to claim good cause for refusing to cooperate by completing this Notice and Agreement;
- Complete the Child Support Questionnaire (CW 2.1Q) for each noncustodial parent or alleged father;
- Establish paternity and get child and/or spousal support;
- Submit to genetic testing if paternity is in question;
- Obtain any other payments or property due any member of your assistance unit;
- Obtain medical support money from any noncustodial parent and, if you get cash aid, obtain child support money;
- Tell the county about medical coverage or money for medical services paid by the noncustodial parent and complete the Health Insurance Questionnaire form (DHS 6155);
- Give the LCSA any medical support money from any noncustodial parent, and any child/spousal support money you get;
- Appear at the county or LCSA office to sign papers or give required facts;
- Appear at hearings or in court when necessary;
- Fill out and sign an Attestation Statement, if asked by the LCSA. On this form you declare under penalty of perjury that you have given all the facts you know about the noncustodial parent/alleged father. If you sign the form and you do not report all the facts or give wrong facts, you can be fined or sent to jail/prison.

Benefits of Cooperation

Your cooperation can help you and your child(ren). Finding the noncustodial parent and establishing paternity may give you and your child(ren) rights to future social security, veterans, or other benefits. The LCSA will continue enforcement after you go off cash aid or Medi-Cal unless you make a request in writing to the LCSA to stop.

Good Cause for Not Cooperating

- Good cause is the right to refuse to cooperate because it is not in the best interests of you or your child(ren).
- You have the right to claim good cause for not cooperating if you have an acceptable reason for refusing to cooperate with the county and the LCSA.
- The back of this form gives you facts about good cause. If you want more facts about good cause and/or refusal to cooperate, ask your worker to explain them to you.

Penalty for Refusal to Cooperate

If you do not have good cause, there are penalties if you refuse to assign support rights, refuse or fail to give the county any support given to you by the noncustodial parent(s), or refuse to cooperate with the LCSA, including in determining paternity.

- **For cash aid applicants/recipients:**

- If you refuse to assign support rights or refuse/fail to give the county any support given to you, you will not be eligible for cash aid or Medi-Cal. Your child(ren) may still be eligible for aid/benefits and your case will be referred to the LCSA.
- If you refuse or fail to cooperate in the paternity or support enforcement process, your family's grant will be lowered by 25 percent until you cooperate and you may not get Medi-Cal. This penalty ends effective the first day of the month in which you do cooperate.

- **For applicants/beneficiaries of Medi-Cal Only:** You will not be eligible for Medi-Cal benefits, but your child(ren) may still be eligible.

Certification and Agreement:

- I understand my rights and responsibilities as written on this notice.
- I understand the rules for assigning support rights to the county.
- I also understand my right to claim good cause.

I agree to cooperate with the county and the LCSA as listed above.

I claim good cause and refuse to cooperate at this time.

NAME OF NONCUSTODIAL PARENT/ALLEGED FATHER

I refuse to assign child/spousal support rights (cash aid).

I refuse to assign medical support rights (cash aid and Medi-Cal).

Signature of Parent or Caretaker Relative,
or Medi-Cal Applicant/Beneficiary

Date

Case Name

Case Number

I certify that I have notified the applicant, cash aid recipient, or Medi-Cal beneficiary of his/her rights and responsibilities by means of this notice and orally as needed.

County Worker's Signature

Worker's Number

Date

YOUR RIGHT TO CLAIM GOOD CAUSE

Reasons for Claiming Good Cause:

- Cooperation would increase the risk of physical, sexual, or emotional harm to the child(ren).
- Cooperation would increase the risk of domestic abuse for the parent or caretaker relative.
- The child(ren) was conceived due to incest or rape.
- Court proceedings are going on for the adoption of the child(ren).
- You are working with an adoption agency to help you decide whether to keep or place the child(ren) for adoption.
- You are cooperating in good faith but are not able to identify or help locate the noncustodial parent.
- You have other credible reasons why cooperation would not be in the best interest of the child(ren).

How to Claim Good Cause:

- If you want to claim good cause, you must tell your worker. You can do this whenever you believe you have good cause not to cooperate.
- You must also complete and sign the Good Cause Claim form which your worker will give you.
- If you claim good cause, you must:
 - Give the county proof that you have good cause for refusing to cooperate.
 - Give the proof to the county within 20 days of claiming good cause. The county will give you more time if it determines that you need more than 20 days to get your proof.
- If you are claiming good cause and it is not possible for you to get proof, tell the worker.

The Role of the County:

- The county reviews your Good Cause Claim and the proof you provide and decides whether you have good cause.
- The county investigates your facts.
- The county will tell you when you need to provide:
 - more proof to support your good cause claim, and/or
 - additional facts so that it will not be necessary to contact the noncustodial parent or alleged father.

What Is Acceptable Evidence to Claim Good Cause for Not Cooperating?

- Birth certificates, medical/mental health, rape crisis, domestic violence program, or police/sheriff records that show that the child(ren) was conceived due to incest or rape.
- Records that show you have asked for help with abuse toward you and/or the child(ren); or records that show evidence of abuse. These records can be from police/sheriff, governmental agency, or court records; facts from a domestic violence program or a professional from whom you have asked for help in dealing with abuse; physical evidence of abuse, or any other evidence that supports an exemption from the cooperation rules.
- Court documents or other records that show that a legal adoption is pending in court.
- A written statement from an adoption agency confirming that you are being helped to decide whether to keep or place your child(ren) up for adoption.
- Credible sworn statements under penalty of perjury about the history of abuse or the increased risk of abuse, from either you or other people who know about the reasons for your good cause claim for not cooperating.

The Role of the Local Child Support Agency (LCSA):

- If you request a hearing on the issue of good cause, the LCSA may take part in that hearing.
- The LCSA may try to establish paternity or collect child support if:
 - Establishing paternity or collecting child support will not increase risk of harm to you or the child(ren).
 - You do not have good cause for refusing to cooperate.
- After the county tells the LCSA that an applicant/recipient has claimed to be exempt from the cooperation rules, the LCSA will not pursue child support enforcement activities unless the applicant/recipient asks for these actions to begin or to begin again.

SUPPORT QUESTIONNAIRE

FOR COUNTY USE ONLY

Instructions:

You must answer ALL questions.
 COMPLETE ONE FORM FOR EACH NONCUSTODIAL PARENT
 OR EACH UNMARRIED FATHER IN THE HOME.

Use ink. Print answer. Check Yes, No, or Unknown.
 Use a separate piece of paper if you need more room.

CWD CASE NAME	LCSA CASE NAME
CWD CASE NUMBER	LCSA CASE NUMBER
CWD WORKER NAME/NO.	LCSA WORKER NAME/NO.
TELEPHONE NUMBER ()	TELEPHONE NUMBER ()

SECTION 1 - COMPLETE THE FOLLOWING ABOUT YOURSELF

NAME (FIRST, MIDDLE, LAST)	MAIDEN NAME	SOCIAL SECURITY NUMBER (SSN)	BIRTHDATE	BIRTH PLACE	RACE
HOME ADDRESS (STREET NUMBER AND NAME, APARTMENT NUMBER, IF ANY)		CITY	STATE	ZIP	TELEPHONE NUMBER ()
YOUR RELATIONSHIP TO CHILDREN		YOUR RELATIONSHIP TO NONCUSTODIAL PARENT/UNMARRIED FATHER IN THE HOME <input type="checkbox"/> Spouse <input type="checkbox"/> Ex-Spouse <input type="checkbox"/> Friend <input type="checkbox"/> Other			

SECTION 2 - COMPLETE THE FOLLOWING ABOUT THE NONCUSTODIAL PARENT OR UNMARRIED FATHER IN THE HOME

A. NAME (FIRST, MIDDLE, LAST)

SOCIAL SECURITY NUMBER (SSN)	<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	BIRTHDATE	BIRTH PLACE
LAST KNOWN ADDRESS (STREET NUMBER AND NAME, APARTMENT NUMBER, IF ANY)	HEIGHT	WEIGHT	EYE COLOR
CITY	STATE	ZIP	HAIR COLOR
WHEN WAS THIS ADDRESS CURRENT?		SCARS, BIRTHMARKS, TATTOOS, NICKNAMES, ETC.	
TELEPHONE NUMBER ()	WHEN DID YOU LAST HEAR FROM OR GET MAIL FROM THIS PARENT?	DOES THIS PARENT LIVE WITH YOU? <input type="checkbox"/> YES <input type="checkbox"/> NO	

B. WHAT KIND OF INCOME DOES NONCUSTODIAL PARENT HAVE? Earnings Unemployment or Disability Insurance Benefits Social Security None Other

LAST KNOWN EMPLOYER: _____ TELEPHONE NUMBER: ()

STREET ADDRESS: _____ TYPE OF WORK: _____

CITY: _____ STATE: _____ ZIP: _____ UNION MEMBER? YES, UNION NAME: _____ NO UNKNOWN

WHEN DID THIS PARENT LAST WORK THERE? _____ UNION ADDRESS: _____

C. DOES THIS PARENT HAVE HEALTH INSURANCE FOR THE CHILDREN? YES NO UNKNOWN

WHO IS COVERED? _____

NAME OF INSURANCE: _____ POLICY NUMBER: _____ DATE OF COVERAGE: _____

D. PARENTS ARE OR HAVE BEEN MARRIED DATE: _____ WHERE: _____ DIVORCED DATE: _____ WHERE: _____ SEPARATED NEVER MARRIED LIVING TOGETHER

E. IS THERE A COURT ORDER FOR SUPPORT? YES NO PENDING

AMOUNT ORDERED \$	HOW OFTEN?	DATE OF COURT ORDER	COURT ORDER NUMBER	LOCATION OF COURT (COUNTY & STATE)
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HOW DOES THE PARENT PAY? TO YOU TO COUNTY PAYS HOUSEHOLD BILLS PAYROLL DEDUCTION OTHER

WHEN DID PARENT LAST PAY? _____ HOW MUCH? \$ _____

F. NAME OF A FRIEND OR RELATIVE OF NONCUSTODIAL PARENT

ADDRESS (NUMBER AND STREET)	RELATIONSHIP TO NONCUSTODIAL PARENT	TELEPHONE NUMBER ()
CITY	STATE	ZIP

G. DOES THIS PARENT OWN ANY MOTOR VEHICLES? YES NO UNKNOWN

MAKE	MODEL	YEAR	LICENSE NO.	STATE
------	-------	------	-------------	-------

H. DOES THIS PARENT OWN A HOUSE, LAND, BUILDINGS, OR BANK ACCOUNTS? YES NO UNKNOWN

WHAT/WHERE: _____

I. IS THIS PARENT CURRENTLY ON PROBATION OR PAROLE? YES NO UNKNOWN

WHAT COUNTY OR STATE? _____

J. HAS THIS PARENT EVER BEEN IN JAIL OR PRISON? YES NO UNKNOWN

IF YES, WHEN/WHERE? _____

K. HAS THIS PARENT EVER BEEN IN THE MILITARY? YES NO UNKNOWN

IF YES, WHEN/WHAT BRANCH? _____

L. ARE YOU ABLE TO IDENTIFY OR HELP LOCATE THE NONCUSTODIAL PARENT? YES NO

SECTION 3 - CHILDREN (IN YOUR HOME) OF THIS PARENT OR UNMARRIED FATHER

NAME OF CHILD	SEX	SSN	BIRTHDATE	BIRTHPLACE, CITY, STATE	PATERNITY DECLARATION		
	<input type="checkbox"/> M <input type="checkbox"/> F		- -		MFG <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> UNK		
	<input type="checkbox"/> M <input type="checkbox"/> F		- -		<input type="checkbox"/> DATE SIGNED	COUNTY	
	<input type="checkbox"/> M <input type="checkbox"/> F		- -		MFG <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> UNK		
	<input type="checkbox"/> M <input type="checkbox"/> F		- -		<input type="checkbox"/> DATE SIGNED	COUNTY	
	<input type="checkbox"/> M <input type="checkbox"/> F		- -		MFG <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> UNK		
	<input type="checkbox"/> M <input type="checkbox"/> F		- -		<input type="checkbox"/> DATE SIGNED	COUNTY	
	<input type="checkbox"/> M <input type="checkbox"/> F		- -		MFG <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> UNK		
	<input type="checkbox"/> M <input type="checkbox"/> F		- -		<input type="checkbox"/> DATE SIGNED	COUNTY	

SECTION 4 - SUPPORT ENFORCEMENT SERVICES (MEDI-CAL ONLY)

I don't want other child support enforcement services.

I DECLARE UNDER PENALTY OF PERJURY UNDER THE LAWS OF THE UNITED STATES OF AMERICA AND THE STATE OF CALIFORNIA THAT THE INFORMATION IN THIS QUESTIONNAIRE IS TRUE, CORRECT AND COMPLETE.

SIGNATURE	DATE
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STATEMENT OF FACTS SUPPORTING ELIGIBILITY FOR AFDC-FOSTER CARE(FC)

INSTRUCTIONS: Complete in ink all questions to the left of the heavy black line. The parent/legal guardian completes the non-shaded sections of this form instead of the BCJA 2 or SAWS 2 at redetermination only; the placement worker/county welfare department is to complete the shaded portions. The placement worker/county welfare department may complete all sections of this form instead of the BCJA 2 or SAWS 2 at application and redetermination when the parent/legal guardian is:

- Not available Not cooperating Deceased Incapacitated

1. Child Name _____ 2. Male Female

3. Address _____

4. Birth date _____ 5. Birthplace _____

6. Social Security # _____ Applied For? Yes No

7. Citizen of U.S.? Yes No 8. Alien Status: _____

9. Does the child have medical insurance? Yes No

If yes, list policy number, company name, and name of policy: _____

10. Does the child have real or personal property? Yes No

If yes, list property type (land, cash, auto, motorcycle, life insurance, trust fund, bank account, bond, etc.) and its value: _____

11. Does the child have income? Yes No Unknown*
If yes, list amounts below. If application pending, check associated box.

Income Type	Amount	Pending
Social Security		<input type="checkbox"/>
Child Support		<input type="checkbox"/>
Railroad Retirement		<input type="checkbox"/>
SSI/SSP		<input type="checkbox"/>
Veteran's Benefits		<input type="checkbox"/>
Salary/Wages		<input type="checkbox"/>
Other (specify)		<input type="checkbox"/>
Total Amount/Month		<input type="checkbox"/>

* If unknown, please explain: _____

12. Name of School or Training Program: _____

TO BE COMPLETED BY PLACEMENT WORKER/COUNTY WELFARE DEPARTMENT STAFF

13. If child has salary/wages, is the child attending school at least half-time? Yes No

14. Does the child have an Independent Living Program Plan? Yes No

COMPLETE BELOW FOR CHILDREN 17 AND OLDER

15. Does the child attend school on a full-time basis? Yes No

16. Expected graduation/completion before 19th birthday? Yes No

ELIGIBILITY WORKER ONLY

DATE: _____

APPLICATION
 REDETERMINATION

CASE NAME _____

CASE NUMBER _____

VERIFICATION

AGE _____

SOCIAL SECURITY NUMBER _____

CITIZENSHIP/ALIEN STATUS _____

DHS 6155

CHILD'S PROPERTY _____

CHILD'S INCOME/PENDING INCOME _____

ILP _____

VERIFIED BY SCHOOL **YES**

SCHOOL ATTENDANCE

GRADUATION

17) PARENTAL INFORMATION				VERIFICATION
	Parent 1	Parent 2	Parent 3	
Name				CHILD SUPPORT REFERRAL
Relationship				
Maiden Name				
Date of Birth				
Birthplace				
Social Security #				
Address				
Telephone #				
U.S. Citizen (yes or no)				
Veteran (Branch, Years in Service, Serial #)				
18) DEPRIVATION -- INITIAL AND REDETERMINATION				DEPRIVATION
A. Is either the mother or father deceased? <input type="checkbox"/> yes, fill-in A1 and skip to #19. Deprivation exists, pending verification. <input type="checkbox"/> no, PROCEED to B. A1. Deceased parent(s) name: _____ <input type="checkbox"/> Location of death: _____ <input type="checkbox"/> Date of death: _____				
B. Did the mother and/or the father relinquish the child or have either parents' parental rights been terminated(TPR)? <input type="checkbox"/> yes, fill-in B1 and skip to #19. Deprivation exists, pending verification. <input type="checkbox"/> no, PROCEED to C. B1. Relinquishing/TPR parent (s): _____ Date of Relinquishment(s) TPR(S): _____				
C. Are the mother and father living together? <input type="checkbox"/> no, skip to #19. Deprivation exists, pending verification <input type="checkbox"/> yes, PROCEED to D.				
D. Is either the mother or father physically or mentally incapacitated? <input type="checkbox"/> yes, skip to #19. Deprivation exists, pending verification. <input type="checkbox"/> no, PROCEED to E.				
E. Is either parent unemployed? <input type="checkbox"/> no, go to #19. <input type="checkbox"/> yes, go to #19.				
TO BE COMPLETED BY COUNTY WELFARE DEPARTMENT AT REDETERMINATION ONLY				DOCUMENTATION IN FILE: <input type="checkbox"/> CA 341 (Medical report) <input type="checkbox"/> Written statement from physician <input type="checkbox"/> other substantiation (EAS 41-430)
19) REDETERMINATION OF DEPRIVATION - GOOD FAITH EFFORTS				
If the parent(s) is unavailable or uncooperative, please list below the good faith efforts made to contact the parent(s) (i.e., 2 phone calls attempted, 2 letters sent, 1 piece of returned mail, 1 home visit attempted, 1 failure to keep scheduled appointment, etc.) to redetermine deprivation.				GOOD FAITH EFFORTS MADE? <input type="checkbox"/> YES <input type="checkbox"/> NO

DIRECTIONS: QUESTIONS 20-23 MUST BE COMPLETED AT INITIAL APPLICATION; QUESTIONS 20-21 MUST ALSO BE COMPLETED AT REDETERMINATIONS WHEN THERE ARE ANY CHANGES TO THE INFORMATION BELOW.

VERIFICATION

20 Parental Financial Information

	Parent 1	Parent 2	Parent 3
Name			
Relationship			
Occupation			
Name of Employer			
Address of Employer			
Work Hours/Month			
Gross Monthly Wage			
Child Support Paid			
Child Support Received			
Disability (State, Workers' Compensation, etc.)			
Unemployment Benefits			
Pensions			
SSI/SSP			
Veteran's Benefits			
Other Monthly Income (i.e., social security, etc.)			
Application for Income Pending (yes, no, or unknown)			
Accounts (checking, savings, etc.)			
Name of Financial Institution			
Address of Financial Institution			
Cash on Hand			
Other Assets			
Personal Property			
Real Property & Address			
Auto (Year/Model)			

PARENTAL INCOME

PARENTAL PENDING INCOME

PARENTAL RESOURCES

TO BE COMPLETED BY PLACEMENT WORKER/COUNTY WELFARE DEPARTMENT STAFF

21: What is the authority for the child's out-of-home placement?

- Voluntary placement agreement (SOC 155) Date: _____
- Relinquishment - Mother Date: _____
- Relinquishment - Father Date: _____
- Termination of Parental Rights Date: _____
- Child/Agency Agreement Date: _____
- Nonrelated legal guardian Date: _____
- Court Order

Check box to indicate in which court order the finding was made. Enter date of hearing/order.

Court Order Findings	Detention Date	Jurisdictional Date	Dispositional Date	Petition/Other Date
a) Continuance in the home is contrary to the welfare of the minor.				
b) Placement and care is vested with the county.				
c) Reasonable efforts to prevent the removal of the child were made or the lack of preplacement preventative efforts was reasonable.				

COURT ORDER FINDINGS MADE?

- FINDING a: YES NO
- FINDING b: YES NO
- FINDING c: YES NO

TO BE COMPLETED BY PLACEMENT WORKER/COUNTY WELFARE DEPARTMENT STAFF AT APPLICATION ONLY			
Check appropriate box.	Yes	No	Insufficient Information
22. Would the services case file support a determination that the parent or relative from whom removed had minimal income and resources and that the child probably would have been eligible for public assistance in the month of removal?			
23. Has the child lived with the parent or relative from whom removed within the last 6 months?			
PARENT/LEGAL GUARDIAN: I DECLARE UNDER PENALTY OF PERJURY THAT THE FOREGOING STATEMENTS ARE TRUE AND CORRECT.			
SIGNATURE OF PARENT/LEGAL GUARDIAN			
COUNTY WHERE SIGNED		DATE	
PLACEMENT WORKER: ALL INFORMATION RECORDED ON THIS FORM IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE.			
SIGNATURE OF PLACEMENT WORKER (NOT APPLICABLE IF PARENT OF LEGAL GUARDIAN AVAILABLE)			
NAME OF AGENCY		DATE	
SIGNATURE OF ELIGIBILITY WORKER		DATE	
SIGNATURE OF ELIGIBILITY WORKER SUPERVISOR		DATE	

VERIFICATION
<input type="checkbox"/> ELIGIBLE FACILITIES REQUIREMENTS MET <input type="checkbox"/> SERVICES REQUIREMENTS MET
<input type="checkbox"/> NOT ELIGIBLE <input type="checkbox"/> ELIGIBLE <input type="checkbox"/> FEDERAL <input type="checkbox"/> NONFEDERAL <input type="checkbox"/> OTHER

PERSONAL INFORMATION NOTICE

Pursuant to the Federal Privacy Act (P.L. 93-679) and the Information Practices Act of 1977 (Civil Code Sections 1798, et. seq.), notice is hereby given for the request of personal information by this form. The requested personal information is voluntary. The principal purpose of the voluntary information is to facilitate the processing of this form. The failure to provide all or any part of the requested information may delay processing of this form. No disclosure of personal information will be made unless permissible under Article 6, Section 1798.17 of the IPA of 1977. Each individual has the right upon request and proper identification, to inspect all personal information in any record maintained on the individual by an identifying particular. Direct any inquiries on information maintenance to your IPA Forms Officer.

DETERMINATION OF FEDERAL AFDC-FC ELIGIBILITY

INSTRUCTIONS: Complete this form in all cases when a juvenile court order has been issued. To be eligible for federal AFDC-FC, items 1 through 6 must be answered YES. Complete all items. Complete the Verification column with information from the JA 2/SAWS 2 or FC 2 and SOC 158A.

Child's Name	Case Name	Case Number	Court Number
Name of Relative From Whom the Child Was Removed		Relationship	Petition Date:

FEDERAL AFDC - FC ELIGIBILITY REQUIREMENTS	VERIFICATION
1. The child meets all general AFDC-FC eligibility requirements as established on the JA2/SAWS 2 or FC 2. <input type="checkbox"/> Yes <input type="checkbox"/> No	
2. The child was removed from the home of a parent or relative by: <input type="checkbox"/> Voluntary placement agreement Date _____ <input type="checkbox"/> Detention Order <input type="checkbox"/> Jurisdictional/Dispositional Order <input type="checkbox"/> Yes <input type="checkbox"/> No Date _____ Date _____ Does Court Order contain requisite language for federal eligibility? <input type="checkbox"/> Yes <input type="checkbox"/> No <ul style="list-style-type: none"> • Reasonable efforts made to prevent removal of child from home. • Continuance in home would be contrary to welfare of child. • Placement and care vested in appropriate agency. The Court Order <input type="checkbox"/> Is in effect <input type="checkbox"/> Dismissed because <ul style="list-style-type: none"> <input type="checkbox"/> Child is 18 or over <input type="checkbox"/> Relinquishment/parental rights terminated 	
3. Does the child meet AFDC linkage requirements (as in effect July 16, 1996) in the month of petition? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes, lived with parent/relative from whom removed in the month of petition and would have been eligible for AFDC had application been made.(POEM determination) <input type="checkbox"/> Yes, lived with parent/relative from whom removed within any of the previous 6 months prior to the month of petition and would have been eligible for AFDC had application been made in the month of petition. (POEM determination) <input type="checkbox"/> No, insufficient information. <input type="checkbox"/> No, does not meet linkage requirements.	
4. Does deprivation exist? <input type="checkbox"/> Yes <input type="checkbox"/> No Death <input type="checkbox"/> Incapacity <input type="checkbox"/> Unemployment <input type="checkbox"/> Absence <input type="checkbox"/>	
5. Is the child in an eligible facility? Give code from reverse side. <input type="checkbox"/> Yes <input type="checkbox"/> No <div style="border: 1px solid black; width: 50px; height: 20px; margin-left: 100px;"></div>	
6. Will payment be made to an eligible payee? Give code from reverse side. <input type="checkbox"/> Yes <input type="checkbox"/> No <div style="border: 1px solid black; width: 50px; height: 20px; margin-left: 100px;"></div>	

IEVS verification
 Other verification

Not Eligible for federal AFDC-FC
 Insufficient Information. Not eligible for federal AFDC-FC
 Eligible for federal AFDC-FC Items 1-6 answered YES

Effective Date of Federal Eligibility _____

Date Completed _____

Eligibility Worker Signature _____

Summary of family circumstances at time of removal:

FC 3 CODES

CODES FOR QUESTION 5: ELIGIBLE FACILITIES

(45-202.5/45-203.4)

- 01 Approved home of relative
- 02 Certified, license-pending
- 03 Licensed family home
- 04 Family home certified by nonprofit FFA licensed by SDSS
- 05 Private, nonprofit group home licensed by SDSS
- 06 Approved facility/family home on an Indian reservation
- 07 Public Child Care institution

CODES FOR QUESTION 6: ELIGIBLE PAYEE

(45-301.11)

- 01 Approved family home
- 02 Licensed, private, nonprofit group home
- 03 Cooperating public or licensed nonprofit private child placement or child care agency with responsibility for placement and care of the child
- 04 Licensed homefinding agency which certified the exclusive-use home in which the child has been placed.

FEDERAL AFDC-FC ELIGIBILITY REQUIREMENTS

Eligibility & Assistance Standards (EAS)

Age	(45-201.11)
Property	(45-201.12)
Residence	(45-201.13)
Citizenship/Alienage	(45-201.14)
Social Security	(45-201.15)
Income/Need	(45-201.2)
Child Support	(45-201.3)
Services	(45-201.4)
Deprivation	(45-201.1)(45-203.1)
With Whom Child Placed	(45-202.2)(45-203.2)
AFDC/FG/U Linkage	(45-202.3)
Authority For Placement	(45-202.4)(45-203.3)
Eligible Facilities	(45-202.5)(45-203.4)
Placement and Care	(45-202.6)(45-203.5)

AFDC-FG/U WORKSHEET

INSTRUCTIONS: Complete the following to determine if the child would have received federal AFDC-FG/U (as it existed July 16, 1996) in the Month of the petition based on the circumstances in the home of the parent or relative from whom the child was removed. The AFDC-FG/U linkage requirement is met when all items are answered YES.

Child's Name	Month of Petition	Date Child Last Resided with Parent or Relative From Whom Removed
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FEDERAL AFDC - FG/U ELIGIBILITY REQUIREMENTS				VERIFICATION	
1. Total Persons in AU/FU	Total 185% MBSAC + Special Needs		Total MBSAC + Nonrecurring Special Needs	EARNINGS VERIFICATION ON FILE: <input type="checkbox"/> Yes <input type="checkbox"/> No UNEARNED VERIFICATION ON FILE: <input type="checkbox"/> Yes <input type="checkbox"/> No OTHER VERIFICATIONS ON FILE (LIST): INCOME LINKAGE ESTABLISHED (185% TEST AND FINANCIAL BIG TEST) <input type="checkbox"/> Yes <input type="checkbox"/> No	
A. 185% of MBSAC INCOME TEST		AMOUNT	B. FINANCIAL ELIGIBILITY TEST		
1. Gross Earnings			1. Gross Earnings		
2. Current Child Support Received by DA or Recipient	+		2. Work-Related Expenses (\$90)		-
3. Other Unearned Income (Specify)	+		3. \$30 and 1/3 Exemption (if applicable)		-
4. Excluded persons Gross Income	+		4. Dependent Care (Up to \$200 each)		-
5.	+		5. NET EARNINGS		=
6.	+		6. Other Nonexempt Income		+
7.	+		7. Child Support Collected by DA		+
8.	+		8. Court Ordered Child Support Paid		-
TOTAL INCOME		=	TOTAL NET NONEXEMPT INCOME		=
Gross Income Eligible?	<input type="checkbox"/> Yes <input type="checkbox"/> No		Financially Eligible?	<input type="checkbox"/> Yes <input type="checkbox"/> No	

2. Is the property of all persons in the AU/FU in the month of the petition below the allowable limit? <input type="checkbox"/> Yes <input type="checkbox"/> No (COMPLETE BELOW.)				RESOURCES VERIFIED: <input type="checkbox"/> Yes <input type="checkbox"/> No
ITEM	NET MARKET VALUE	ITEM	NET MARKET VALUE	
a. Cash and Securities		f.	+	
b. Cash Surrender Value of Life Insurance	+	g. Real Property (Specify)	+	
c. Motor Vehicle	+	h.	+	
d. Other Personal Property (Specify)	+	i.	+	
e.	+	J. TOTAL PROPERTY	=	

AFDC-FG U LINKAGE DETERMINATION:
 NOT ELIGIBLE FOR FEDERAL AFDC-FG U in month of petition
 INSUFFICIENT INFORMATION Not eligible for federal AFDC-FG U
 Eligible for federal AFDC-FG U in month of petition

DATE: _____

NOTIFICATION OF AFDC-FOSTER CARE TRANSFER

SECTION A - SENDING COUNTY COMPLETES (PLEASE TYPE OR PRINT)

CASE NAME	CASE NUMBER	CHILD'S PARENTS' NAME(S)
CHILD'S NAME	CHILD'S SOCIAL SECURITY NUMBER	DA CHILD SUPPORT NUMBER(S)
SENDING COUNTY ADDRESS		PAYEE NAME (IF FAMILY PLACEMENT - RELATIONSHIP)
RECEIVING COUNTY ADDRESS		ADDRESS OF FOSTER HOME OR INSTITUTION
DISCONTINUANCE DATE/END OF TRANSFER PERIOD		DATE JURISDICTION TRANSFERRED

TELEPHONE NUMBER:
()

CURRENT PAYMENT AMOUNT:	BASIC RATE: \$	SPECIALIZED CARE RATE: \$	INFANT SUPPLEMENT: \$	CURRENT CLOTHING ALLOWANCE: \$	<input type="checkbox"/> INITIAL <input type="checkbox"/> ANNUAL:
AID PROGRAMS:	<input type="checkbox"/> FEDERAL FOSTER CARE <input type="checkbox"/> MEDI-CAL ONLY	<input type="checkbox"/> STATE FOSTER CARE <input type="checkbox"/> COUNTY ONLY	<input type="checkbox"/> EMERGENCY ASSISTANCE "NOT-TO-EXCEED DATE:"		

DOCUMENTATION:

ENCLOSED N/A

- EA AUTHORIZATION DOCUMENTS [EA 1/ ACE SCREEN PRINT, OR OTHER DOCUMENTS]
- SAWS 1
- FC 2/JA 2
- SOC 158A OR EQUIVALENT: _____
- BIRTH CERTIFICATE/ALIEN STATUS DOCUMENTATION
- SOCIAL SECURITY NUMBER DOCUMENTATION
- FC 3/FC 3A - VERIFICATION OF DEPRIVATION
- EVIDENCE SUPPORTING FEDERAL ELIGIBILITY [LINKAGE & DEPRIVATION]
- COURT ORDER/AUTHORITY FOR PLACEMENT DOCUMENTATION
 - DETENTION ORDER
 - TRANSFER OF JURISDICTION
 - JURISDICTION ORDER
 - PERMANENCY HEARING ORDER(S) WITH REASONABLE EFFORTS FINDINGS
- PROPERTY OF MINOR/TRUST INFORMATION
- INCOME OF MINOR: _____ TYPE: _____ AMOUNT \$ _____
- INDEPENDENT LIVING PLAN
- 18 YEARS OLD AND OVER DOCUMENTS [MUTUAL AGREEMENT, SCHOOL VERIFICATION]
- DHS6155 HEALTH INSURANCE QUESTIONNAIRE
- APPLICATIONS PENDING (SSI/SSP)
- FC 4
- OTHER:

SOCIAL WORKER'S NAME	SOCIAL WORKER NUMBER	SOCIAL WORKER'S TELEPHONE NUMBER ()
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COMMENTS:

ELIGIBILITY WORKER'S NAME	ELIGIBILITY WORKER NUMBER	ELIGIBILITY WORKER'S TELEPHONE NUMBER ()
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SECTION B: RECEIVING COUNTY COMPLETES: (PLEASE TYPE OR PRINT)

<input type="checkbox"/> TRANSFER ACCEPTED <input type="checkbox"/> CASE ELIGIBLE - WILL BEGIN ON:	<input type="checkbox"/> TRANSFER NOT ACCEPTED - REASON: <input type="checkbox"/> CASE INELIGIBLE - REASON:
---	--

ELIGIBILITY WORKER'S NAME	ELIGIBILITY WORKER NUMBER	ELIGIBILITY WORKER'S TELEPHONE NUMBER ()
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DISTRICT OFFICE