



# TITLE IV-E TITLE XIX APPLICATION - FOSTER CARE

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CHILDREN AND FAMILY SERVICES-FOSTER CARE  
SFN 641 (11-2024)

Office Use Only

Date Received

Case Number

## Instructions for Application

This application is used for foster care eligibility and Medical Assistance for children entering foster care. Foster care is defined as full-time substitute care of children outside their own home by people other than their biological or adoptive parent(s) or legal guardian(s). Eligibility determination requires all questions to be answered.

The information provided on the application must be specific to the legal removal home of the biological or adoptive parent(s) or legal guardian(s) and the household members living at the residence at the time of removal in the eligibility month.

## ELIGIBILITY MONTH (Application Month)

The foster care eligibility month is defined as the month during which the petition for the care of the child, which eventually led to a court ordered removal of the child, is filed. If no petition is filed, it is the month in which the child was removed through an emergency court order.

Court Ordered Removal Month and Year

If a petition was filed which led to the legal removal, specify the petition month and year:

Complete the application based on household status in the petition month. If no petition month is listed, complete the application based on court-ordered removal month.

## Address of the Legal Removal Home

Name of Applicant

Relationship to Child Removed from this Address

Mother  Father  Legal Guardian  18+ foster care child returning to care  Other (specify):

Physical Address

City

State

ZIP Code

Cell Phone Number

Home Telephone Number (land line)

Work Telephone Number

County

Mailing Address (if different from physical address)

City

State

ZIP Code

## Address of Where Children Resided at Time of Removal

If child is 18+ and returning to foster care, skip this section.

Same as address of legal removal home

If the child(ren) lived at a residence other than the one listed above, provide the following:

Name of Primary Resident		Is this a relative to the child? <input type="checkbox"/> Yes <input type="checkbox"/> No		If relative, what is the relationship?	
Address		City		State ZIP Code	
Cell Phone Number	Home Telephone Number (land line)	How long has the child lived at this residence?			
Did the biological or adoptive parent or legal guardian live with the child at this residence in the six month prior to the removal month? <input type="checkbox"/> Yes <input type="checkbox"/> No		If yes, when was the last time they lived at this residence?			

### Tell Us About the People in the Legal Removal Home

Check the boxes below for all the people who live in this home  
 Applicant    Spouse    Biological/Adopted Children    Stepchildren    Other adults or children living in your home

**For each person checked, fill in the boxes below. These people make up your household.**  
**List all household members** living at the residence at the time of removal include child(ren) removed in eligibility month

Household Members (Enter Legal Name)			Relationship to You	Social Security Number	Date of Birth	Age	Sex	Last Grade Com- pleted	U. S. Citizen (Yes or No)	Hispanic or Latino (Yes or No)	Race	Marital Status
First	Middle Initial	Last									Use Codes Below	
			Self									

**Race Codes:** **AI** - American Indian/Alaska Native   **AP** - Asian   **BL** - Black/African American   **HP** - Native Hawaiian/Pacific Islander   **WH** - White  
**Marital Status Codes:** **DI** - Divorced   **MA** - Married   **NM** - Never Married   **SE** - Separated   **WI** - Widowed

If any household members are enrolled member in a federally-recognized Indian tribe, list enrolled members, the name of the tribe and their tribal enrollment numbers:

If any household member is disabled, list disabled household member and explain disability

For any foster care child who is not a US Citizen or US National, what is their immigration status?

List Document Type

List Document Number

### Child(ren) Placed in Foster Care

1. Name of Child

Student Status  
 N/A    Part Time    Full Time

Name of School

List the City and State Where Child Was Born

Was child adopted?  
 Yes    No

If adopted, does the family receive a subsidy payment?  
 Yes    No

If family receives a subsidy payment, who administers the payment?  
 HHS    Out-of-State Agency (specify):

Is this child a tax filer?  
 Yes    No

Is this child a tax dependent?  
 Yes    No

Name of Biological or Adoptive Mother

Date of Birth

Was Mother residing with child at time of removal?  
 Yes    No-where does child's mother live?

If No, List Reason for Mother's Absence

Address

City

State

ZIP Code

Name of Biological or Adoptive Father

Date of Birth

Was Father residing with child at time of removal?  
 Yes    No-where does child's father live?

If No, List Reason for Father's Absence

Address

City

State

ZIP Code

Child(ren) Placed in Foster Care			
2. Name of Child		Student Status <input type="checkbox"/> N/A <input type="checkbox"/> Part Time <input type="checkbox"/> Full Time	
Name of School			Was child adopted? <input type="checkbox"/> Yes <input type="checkbox"/> No
List the City and State Where Child Was Born		Was child adopted? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If adopted, does the family receive a subsidy payment? <input type="checkbox"/> Yes <input type="checkbox"/> No		If family receives a subsidy payment, who administers the payment? <input type="checkbox"/> HHS <input type="checkbox"/> Out-of-State Agency (specify):	
Is this child a tax filer? <input type="checkbox"/> Yes <input type="checkbox"/> No		Is this child a tax dependent? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Name of Biological or Adoptive Mother			Date of Birth
Was Mother residing with child at time of removal? <input type="checkbox"/> Yes <input type="checkbox"/> No-where does child's mother live?			If No, List Reason for Mother's Absence
Address		City	State ZIP Code
Name of Biological or Adoptive Father			Date of Birth
Was Father residing with child at time of removal? <input type="checkbox"/> Yes <input type="checkbox"/> No-where does child's father live?			If No, List Reason for Father's Absence
Address		City	State ZIP Code

3. Name of Child		Student Status <input type="checkbox"/> N/A <input type="checkbox"/> Part Time <input type="checkbox"/> Full Time	
Name of School			Was child adopted? <input type="checkbox"/> Yes <input type="checkbox"/> No
List the City and State Where Child Was Born		Was child adopted? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If adopted, does the family receive a subsidy payment? <input type="checkbox"/> Yes <input type="checkbox"/> No		If family receives a subsidy payment, who administers the payment? <input type="checkbox"/> HHS <input type="checkbox"/> Out-of-State Agency (specify):	
Is this child a tax filer? <input type="checkbox"/> Yes <input type="checkbox"/> No		Is this child a tax dependent? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Name of Biological or Adoptive Mother			Date of Birth
Was Mother residing with child at time of removal? <input type="checkbox"/> Yes <input type="checkbox"/> No-where does child's mother live?			If No, List Reason for Mother's Absence
Address		City	State ZIP Code
Name of Biological or Adoptive Father			Date of Birth
Was Father residing with child at time of removal? <input type="checkbox"/> Yes <input type="checkbox"/> No-where does child's father live?			If No, List Reason for Father's Absence
Address		City	State ZIP Code

4. Name of Child		Student Status <input type="checkbox"/> N/A <input type="checkbox"/> Part Time <input type="checkbox"/> Full Time	
Name of School			Was child adopted? <input type="checkbox"/> Yes <input type="checkbox"/> No
List the City and State Where Child Was Born		Was child adopted? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If adopted, does the family receive a subsidy payment? <input type="checkbox"/> Yes <input type="checkbox"/> No		If family receives a subsidy payment, who administers the payment? <input type="checkbox"/> HHS <input type="checkbox"/> Out-of-State Agency (specify):	
Is this child a tax filer? <input type="checkbox"/> Yes <input type="checkbox"/> No		Is this child a tax dependent? <input type="checkbox"/> Yes <input type="checkbox"/> No	

### Child(ren) Placed in Foster Care (continued)

**Child 4 Continued:**

Name of Biological or Adoptive Mother		Date of Birth	
Was Mother residing with child at time of removal? <input type="checkbox"/> Yes <input type="checkbox"/> No-where does child's mother live?		If No, List Reason for Mother's Absence	
Address	City	State	ZIP Code
Name of Biological or Adoptive Father		Date of Birth	
Was Father residing with child at time of removal? <input type="checkbox"/> Yes <input type="checkbox"/> No-where does child's father live?		If No, List Reason for Father's Absence	
Address	City	State	ZIP Code

### Tell Us About Your Household's Assets

**Vehicles**

List vehicles (car, truck, motor home, snowmobile, motorcycle, 3 wheeler/4 wheeler, boat or other watercraft, camper, trailer, etc.) owned, jointly owned or being purchased for all household members, even if the vehicle is not running or not in your possession. Include vehicles licensed through North Dakota, tribal motor vehicle or another state.

Make/Model	Year	Value	Amount Owed	Licensed	Owners
				<input type="checkbox"/> Yes <input type="checkbox"/> No	
				<input type="checkbox"/> Yes <input type="checkbox"/> No	
				<input type="checkbox"/> Yes <input type="checkbox"/> No	

**Other Assets**

Check yes by the assets owned, jointly owned, or being purchased by household members. Check no, if none.

- |                                                                                                           |                                                                                                                 |
|-----------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------|
| <input type="checkbox"/> Yes <input type="checkbox"/> No Annuities                                        | <input type="checkbox"/> Yes <input type="checkbox"/> No Individual Indian Monies (IIM) Accounts *              |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Assets Owned with Another Person                 | <input type="checkbox"/> Yes <input type="checkbox"/> No Inheritance                                            |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Burial Plots                                     | <input type="checkbox"/> Yes <input type="checkbox"/> No Life Estate/Life Lease                                 |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Burial Space Items (Casket, Vault, Marker, etc.) | <input type="checkbox"/> Yes <input type="checkbox"/> No Mineral Rights (Oil, Gas, Gravel, Coal, etc.)          |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Business Accounts                                | <input type="checkbox"/> Yes <input type="checkbox"/> No Money Market Account                                   |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Business Inventory/Equipment                     | <input type="checkbox"/> Yes <input type="checkbox"/> No Notes or Contract for Deed                             |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Cash on Hand                                     | <input type="checkbox"/> Yes <input type="checkbox"/> No Prepaid Funeral Plans                                  |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Certificates of Deposit                          | <input type="checkbox"/> Yes <input type="checkbox"/> No Real Property (Land, Rental Property, Buildings, etc.) |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Checking/Credit Union Accounts                   | <input type="checkbox"/> Yes <input type="checkbox"/> No Retirement Funds (IRA/KEOGH/401K)                      |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Debit Card Account (Not Checking/Savings)        | <input type="checkbox"/> Yes <input type="checkbox"/> No Safe Deposit Box                                       |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Farm Equipment, Livestock, Stored Grain          | <input type="checkbox"/> Yes <input type="checkbox"/> No Savings Bonds                                          |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Home/Mobile Home (Not Owner Occupied)            | <input type="checkbox"/> Yes <input type="checkbox"/> No Savings/Credit Union Accounts                          |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Home/Mobile Home (Owner Occupied)                | <input type="checkbox"/> Yes <input type="checkbox"/> No Stocks/Bonds/Mutual Funds                              |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Income Producing Tools/Equipment                 | <input type="checkbox"/> Yes <input type="checkbox"/> No Trusts                                                 |

\* IIM information is required for foster care eligibility only

Other, specify: \_\_\_\_\_

For all items checked yes, fill in the boxes below:

Type of Asset	Location/Description	Total Value	Amount Owed	Owners

Does any household member have life insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, fill in the boxes below:					
Name of Inured Person	Name and Address of Company	Policy Number	Face Value	Cash Surrender Value	Owners

**Unearned Income or Other Money Received**

The following is a list of different kinds of unearned income. Check yes for each unearned income or other money received by household members. Check no, if not received.

- |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <input type="checkbox"/> Yes <input type="checkbox"/> No Benefit while on Strike<br><input type="checkbox"/> Yes <input type="checkbox"/> No Bingo/Gambling Winnings<br><input type="checkbox"/> Yes <input type="checkbox"/> No Child Support or Spousal Support<br><input type="checkbox"/> Yes <input type="checkbox"/> No Contract Sale or Rental Income<br><input type="checkbox"/> Yes <input type="checkbox"/> No Foster Care/Subsidized Adoption Payments<br><input type="checkbox"/> Yes <input type="checkbox"/> No Income from CRP<br><input type="checkbox"/> Yes <input type="checkbox"/> No Income from Tribes<br><input type="checkbox"/> Yes <input type="checkbox"/> No Income from Roomer/Boarder<br><input type="checkbox"/> Yes <input type="checkbox"/> No Individual Indian Monies (IIM) *<br><input type="checkbox"/> Yes <input type="checkbox"/> No Insurance/Lawsuit Settlement<br><input type="checkbox"/> Yes <input type="checkbox"/> No Interest/Dividend Income<br><input type="checkbox"/> Yes <input type="checkbox"/> No Money Deposited into a Bank Account from an Individual Outside of Your Household | <input type="checkbox"/> Yes <input type="checkbox"/> No Money from Inheritance<br><input type="checkbox"/> Yes <input type="checkbox"/> No Oil/Mineral Rights/Royalties<br><input type="checkbox"/> Yes <input type="checkbox"/> No Pension/Retirement Benefits<br><input type="checkbox"/> Yes <input type="checkbox"/> No Railroad Benefits<br><input type="checkbox"/> Yes <input type="checkbox"/> No Refugee Assistance<br><input type="checkbox"/> Yes <input type="checkbox"/> No Social Security Benefits<br><input type="checkbox"/> Yes <input type="checkbox"/> No Supplemental Security Income (SSI)<br><input type="checkbox"/> Yes <input type="checkbox"/> No Unemployment Benefits<br><input type="checkbox"/> Yes <input type="checkbox"/> No Veteran's/Military Benefits<br><input type="checkbox"/> Yes <input type="checkbox"/> No Workers' Compensation<br><br>Other, specify: _____ |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|

\* IIM information is required for foster care eligibility only

For all items checked yes, fill in the boxes below:

Type of Unearned Income or Other Money Received	Household member	How Often Received	Amount This Month	Amount Next Month

Does anyone outside of your household deposit money into a household member's bank account?  Yes  No If yes, explain:

Have household members applied for benefits not yet received (such as Social Security, SSI, Worker's Compensation, Unemployment Compensation, Veterans/Military Benefits, etc.?)  Yes  No If yes, explain:

**Tell Us About Expenses**

Is any household member court ordered to pay child support, spousal support, other support or health insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No		
If yes, who?	Who are the payments for?	
Amount Court Ordered	Amount Paid	
Does your household have child care expenses? <input type="checkbox"/> Yes <input type="checkbox"/> No	Billed Amount	Amount You Pay
Are you receiving child care assistance? <input type="checkbox"/> Yes <input type="checkbox"/> No	Have you applied for child care assistance? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Do you expect any changes in these expenses next month? <input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, Explain	

**Tell Us About Expenses (continued)**

Does anyone help you pay any of these expenses?  Yes  No If yes, fill in the boxes below:

Expense	Who Pays	Amount Paid

**Tell Us About the Income/Money Your Household Receives**

**Self-Employment**

Are any household members self-employed?  Yes  No

If yes, answer below:

Name of Household Member(s)	Name of Business
Type of Business	Date Business Started

Amount of Net Self-Employment Income (profits once business expenses are paid):

Amount in Eligibility Month	Amount Last Month	Amount Two Months Prior to Eligibility Month
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**Employment**

Are any household members employed?  Yes  No

If Yes, list information about pay from employment such as wages, commissions, bonuses, and incentives for all household members, including children. If employment stopped last month or this month, also list income received this month here.

Household Members	Employer	Hours Worked Per Week	Hourly Pay	This Month's Pay Before Taxes (Gross)	Next Month's Pay Before Taxes (Gross)	Amount of Tips	Date of Next Check	How Often Paid	Day or Dates Paid
								Use Codes Below	

How Often Paid Codes:  
**M** - Monthly    **2X** - Twice a Month    **W** - Weekly    **EX** - Every Two Weeks    Other, specify: \_\_\_\_\_

Day Paid Codes:  
**M** - Monday    **T** - Tuesday    **W** - Wednesday    **TH** - Thursday    **F** - Friday    **S** - Saturday    **SU** - Sunday

**Unemployed Parents Living in the Household**

Applies only to a two parent biological/adoptive household

Name of Biological or Adoptive Parent Living in the Same Household	Earnings in Last 24 Months	Hours Worked in Eligibility Month	Hours Worked Last Month	Hours Worked Last Month Prior to Eligibility Month

## Your Health Insurance Coverage

List household members who have health insurance:

Persons Covered	Policy Holder Name and Address	Health Insurance Name, Address, and Telephone Number	Effective Date	Policy Number	Group Number	Monthly Premium	Type of Coverage
							Use Codes Below

- List all that apply
- |                                                                                                     |                                                                                                 |                                                                                                                                                              |                                                                                                                                                          |
|-----------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>A</b> - Hospital<br><b>B</b> - Doctor<br><b>C</b> - Major Medical/Lab/X-Ray<br><b>D</b> - Dental | <b>E</b> - Vision<br><b>F</b> - Nursing Home<br><b>G</b> - Cancer<br><b>H</b> - Champus/Tricare | <b>I</b> - HMO Insurance<br><b>J</b> - Court Ordered<br><b>K</b> - Medicare Part A<br><b>L</b> - Medicare Part B<br><b>M</b> - Medicare Supplement/Advantage | <b>N</b> -Prescription Drug Insurance<br><b>P</b> - Workers Compensation or Accident<br><b>V</b> - Veterans Administration<br><b>W</b> - Medicare Part D |
|-----------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------|

### CHILD SUPPORT

Federal law requires enforcement of the legal obligations of parents to support their dependent children. Potential benefits to them include their future right to inheritance; social security, veterans or other government benefits; and the knowledge that they are being supported, at least in part, by their absent parent(s).

You have "good cause" not to cooperate with the state's effort to establish paternity or child/medical support if you can show that your cooperation might be contrary to the best interest of your child. You must be able to provide evidence to support this claim.

If you think you may want to file a "good cause" exemption from the requirement to cooperate, complete the Notice of Right to Claim "Good Cause" SFN 443. Page 2 of the SFN 443 provides a more detailed written explanation of the circumstances under which "good cause" may be established and the type of evidence needed to decide the issue.

If you want to claim "good cause", you must complete a Request to Claim "Good Cause" SFN 446, which is available from your local human service zone office or online at: <https://www.nd.gov/eforms/>

Claiming "good cause" does not affect you or your child's eligibility.

### CONFIDENTIALITY STATEMENT

Federal and state laws and regulations limit the use and disclosure of confidential information concerning applicants and recipients of Medicaid programs to purposes directly related to the administration of this program.

The Privacy Act of 1974 (P. L. 93-579, Section 7) requires the following information be provided when individuals are requested to disclose their social security numbers. Disclosure of the Social Security number is voluntary and it is requested for identification purposes. Failure to disclose this information will not affect participation in this program.

### YOUR RIGHTS AND RESPONSIBILITIES

**CHANGES** - I understand the agency needs to know of certain changes in income, assets, persons entering or leaving my home, and address changes. I understand that I must report these changes to the agency within (10) days.

**FAIR HEARINGS** - I understand that if I disagree with a decision made regarding my case, I have the right to ask for a fair hearing. Should I wish to request a fair hearing, I can receive instructions on how to do so by contacting the human service zone.

**HOME VISITS** - I understand that a department representative may make a scheduled home visit and may contact other people in order to verify my eligibility for assistance.

**VERIFICATION** - I understand that information may be verified by federal, state, or local officials and that information may be submitted to the Immigration and Naturalization Service. I also understand that information I give will be verified by computer cross matching with other agencies and private sectors. I understand that when federal and state personnel verify the information on this application, if what I reported is found to be incorrect, my child's Medicaid case may be denied or terminated, and I may be subject to criminal prosecution.

**PENALTIES FOR FRAUD** -Federal regulations require state Medicaid agencies to inform recipients of the federal penalties for fraud under Section 1090 of the Social Security Act.

### **SECTION 1909 OF THE SOCIAL SECURITY ACT; (Penalties)**

Whoever-

- (1) knowingly and willfully makes or causes to be made any false statement or representation of a material fact in any application for any benefits for payment under the state plan approved under this title,
- (2) at any time knowingly and willfully made or causes to be made any false statements or representation of a material fact for use in determining rates to such benefits or payment,
- (3) having knowledge of the occurrence of any event affecting (a) his initial or continued right to any such benefit or payment, or (b) the initial or continued right to any such benefit or payment of any other individual in whose behalf he has applied for or is receiving such benefit or payment, conceals or fails to disclose such event with an intent fraudulently to secure such benefit or payment either in a greater amount or quantity than is due or when no such benefit or payment is authorized, or
- (4) having made application to receive any such benefit or payment for the use and benefit of another and having received it, knowingly and willfully converts such benefit for payment or any part thereof to a use other than for the use and benefit of such other person,

shall be guilty of a misdemeanor and upon conviction thereof shall be fined not more than \$10,000 or imprisoned for not more than one year, or both.

### **ASSIGNMENT**

When you receive Medicaid, you give the State of North Dakota any rights to medical support and the payment of medical care from any third party for services received. You must help the state in pursuing any third party who may have a responsibility to pay for care or services. You must also report any payments you receive for medical care within 10 days of receiving the payment. When you receive TANF, you give to the State of North Dakota your right to child support.

### **ASSIGNMENT OF SUPPORT RIGHTS**

Under North Dakota law, eligibility for foster care automatically creates an assignment of all support rights for the child named above to the Department of Health and Human Services. This assignment covers all support rights (accrued, present, pending and continuing) for all persons named above, whether arising from an order of a court, administrative agency or otherwise. This assignment will remain in effect until terminated by the Department of Health and Human Services, as assignee.

### **AUTHORIZATION TO RELEASE INFORMATION**

I/We authorize any person having custody or knowledge of the information relating to me or other household members to disclose any requested information, including confidential information other than protected health information, to any authorized agent of the Department of Health and Human Services. I authorize the Department of Health and Human Services and the carrier providing Healthy Steps insurance to release to each other information regarding any services or benefits I received under Healthy Steps. This authorization will remain valid until assistance ends or until revoked in writing. I/we authorize Child Support to release any records of child support payments that I/we have made or received. A copy of this authorization is as valid as the original.

### **SIGNATURE**

State and federal law provide for fine, imprisonment, or both for any person guilty of obtaining assistance to which he is not entitled by willfully withholding or giving false information. I agree to inform the human service zone office within ten (10) days of changes in income, assets, number of persons in household, address or living arrangements which might affect my child's right to receive assistance. My signature on this form authorizes the use of social security number(s) for the use in administering any program for which I applied.

**I certify under penalty of perjury, that the information contained on this report is true, including the information concerning citizenship and alien status of members applying for benefits.**

### **Sign And Date the Application Here**

Signature of Applicant	Date
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Brochures and forms for the following are located on the Department of Health and Human Services website at:

<https://www.hhs.nd.gov/CFS/publications-children-and-family-services>

- Civil Rights/Nondiscrimination Policy - Civil Rights Complaint
- Health Tracks - preventative health screenings for children
- Child Support Information for Parents with Children in Foster Care
- North Dakota Family Planning Program - designed to help women and men to understanding and take responsibility for their health through education and services