TITLE IV-E ADOPTION SUBSIDY CERTIFICATION

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CHILDREN AND FAMILY SERVICES-ADOPTIONS
SFN 854 (5-2024)

Clear Fields

This form is to be completed by the Human Service Zone (HSZ) or tribal case manager on behalf of the child. This form is to be completed prior to the pre-adoptive placement. An updated form must be completed if placement does not occur within one year.

* In compliance with the Federal Privacy Act of 1974, 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.

Child's Name		
Date of Birth	Social Security Number*	Sex

1. Is the child eligible to receive SSI benefits?
   ☐ Yes ☐ No If yes, indicate amount: **and attach copy of SSI Eligibility Determination**
2. Is the child a child of a minor parent who is in foster care and receiving Title IV-E foster care payments that cover both the minor parent and child?
   ☐ Yes ☐ No
3. Is the child a former recipient of Title IV-E adoption assistance prior to the adoptive parents death or termination of their parental rights?
   ☐ Yes ☐ No
4. Does the child own any resources? (Assets may include savings, trusts, Indian Monies (IM) accounts)
   ☐ Yes ☐ No If yes, attach documentation as to the amount and source of the resource.
5. Does the child receive any other income?
   ☐ Yes ☐ No If yes, indicate the type and the amount.
   ☐ SSA _____ ☐ VA _____ ☐ RR _____ ☐ Other _____
6. What type of foster care placement is the child currently in?
   ☐ Non-Paid Placement
   ☐ Paid Foster Care
   ☐ TANF/Kinship Care
7. Does the child receive additional reimbursement for:
   ☐ Monthly EMP (If this is marked, provide the SFN 1865 Foster Care Child Needs Assessment to the licensed child placing agency)
   Monthly EMP Amount
   ☐ Child Care for Working Parent (Average cost over a one year period)
   Average Monthly Rate

I HAVE COMPLETED THIS FORM AS A REPRESENTATIVE OF THE AGENCY PROVIDING A FOSTER CARE PAYMENT FOR THIS CHILD AND CERTIFY THAT THE INFORMATION GIVEN ON THIS FORM IS TRUE AND COMPLETE TO THE BEST OF MY KNOWLEDGE.

Signature of Worker	Telephone Number	Date

For State Office Use:

Current Regular Monthly Foster Care Rate for Youth's Age Amount	Initials of State Worker	Date

DISTRIBUTION: **Original:** Return to Adoption Specialist **Copies:** HSZ or Tribal file and LCPA file