TITLE IV-E ADOPTION SUBSIDY CERTIFICATION

NORTH DAKOTA DEPARTMENT OF HUMAN SERVICES
CHILDREN AND FAMILY SERVICES-ADOPTION
SFN 854 (6-2021)

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 in the month of the projected date of adoptive placement.

Child's Name:		CCWIPS Case Number:
Date of Birth:	Social Security Number:*	Sex:
Citizenship: ☐ Yes ☐ No	Resident of North Dakota? ☐ Yes ☐ No	Indian Enrollment Number:

Date Adoption Proceedings Initiated (the month in which you anticipate the child is to be placed for adoption):

1. Has it been determined that the child cannot/should not return to the home of his parents through a court order terminating parental rights?
☐ Yes ☐ No

2. Was the child Title IV - E eligible at the time of the initial removal from the home?
☐ Yes ☐ No

3. Was the child eligible to receive IV - E foster care maintenance payments in the month adoption proceedings were initiated?
☐ Yes ☐ No

4. Was the child eligible to receive SSI benefits in the month adoption proceedings were initiated?
☐ Yes ☐ No If yes, indicate amount _____ **and attach copy of SSI Eligibility Determination**

5. 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, in the month the adoption proceedings were initiated?
☐ Yes ☐ No

6. Was 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

7. Did the child own any resources in the month adoption proceedings were initiated?
☐ Yes ☐ No
If yes, attach documentation as to the amount and source of the resource.

8. Did the child receive any other income in the month adoption proceedings were initiated?
☐ Yes ☐ No If yes, indicate the type and the amount.
☐ SSA _____ ☐ VA _____ ☐ RR _____ ☐ Other _____

9. Will the child be in a paid foster care setting in the month the adoptive placement is planned?
☐ Yes ☐ No
What level of care will they receive?
☐ Non-Paid Placement
☐ Family Foster Care
☐ Qualified Residential Treatment Program (QRTP)
☐ Therapeutic (Specify Level):
☐ Intensive Therapeutic ☐ Therapeutic ☐ Step Down/Regular

Does the child receive additional reimbursement for:
☐ Monthly EMP ☐ Child Care for Working Parent

Monthly EMP Amount:	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:

* 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.

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