TITLE IV-E ADOPTION SUBSIDY CERTIFICATION

NORTH DAKOTA DEPARTMENT OF HUMAN SERVICES
CHILDREN AND FAMILY SERVICES-ADOPTION
SFN 854 (2-2018)

Clear Fields

This form is to be completed by a representative of the county making a foster care payment 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:*	Heritage:	Sex:
Citizenship:	Resident of North Dakota? ☐ Yes ☐ No	Indian Enrollment Number:	

Date Adoption Proceedings Initiated (the month in which 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 eligible to receive IV - E foster care maintenance payments in the month adoption proceedings were initiated?
   ☐ Yes ☐ No

3. Was the child Title IV - E eligible at the time of the initial removal from the home?
   ☐ 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, please attach SFN 869 - "Title IV-E Initial Eligibility" or SFN 642 - "Title IV-E, Title XIX Redetermination" to document resources.

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. Please note the most recent foster care rate paid on behalf of this child.

Monthly Rate:	Monthly EMP Amount:	Average Monthly Amount of Child Care Paid for Working Parent:

IN ADDITION TO THE DOCUMENTATION REQUESTED ABOVE, **PLEASE ATTACH SFN 869 - "TITLE IV-E INITIAL ELIGIBILITY" AND THE INITIAL COURT ORDER AUTHORIZING FOSTER CARE** (UPON WHICH THE IV-E DETERMINATION WAS MADE) TO THIS FORM AND RETURN TO THE ADOPTION SPECIALIST.

I 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: - County file, NDDHS and LCPA file