TRIBAL EXCEPTION REFERRAL FOR ADULTS ADOPTING SPECIAL KIDS PROGRAM (AASK)

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CHILDREN FAMILY SERVICES-ADOPTIONS
SFN 923 (2-2024)

Clear Fields

Directions: ND Tribal Social Services will complete this referral and provide the supplemental information to AASK for the purposes of adoption services.

* 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.

A. YOUTH'S INFORMATION

Name (First, Middle, Last)	Social Security Number*	Date of Birth
Gender ☐ Male ☐ Female ☐ Other (specify):	ND Medicaid Number	
Funding Source ☐ IV-E ☐ 638 ☐ Other (specify):	Race	Hispanic ☐ Yes ☐ No ☐ Unknown
Is the youth enrolled in the Tribe? ☐ Yes-Include Enrollment Number: _____ ☐ No-Describe Status of Enrollment Application: _____		
Is the youth eligible to be enrolled in a different Tribe? ☐ Yes ☐ Yes	If Yes, Explain	
Next Child and Family Team Meeting Date and Time		

B. HEALTH AND DEVELOPMENT

Place of Birth (facility name, town, state)			
Name	Facility	Date of Last Appointment	Concerns, Diagnosis, or Follow-up Needed
Primary Physician			
Dentist			
Ophthalmologist			
Mental Health Therapist			
Psychologist			
Psychiatrist			
Occupational Therapist			
Physical Therapist			
Speech Therapist			
Health Tracks Location/Facility			
If the youth ever received Early Intervention Services, list facility name and location:			
Nexus-PATH Worker's Name (if applicable)			

List Additional Providers

List any childhood diseases, allergies, surgeries (include dates), and pertinent health information

Medications

Medication Name	Dose	Medication Name	Dose

Use another page if additional room is needed.

C. EDUCATION

School Name		Current Grade
Educational Supports ☐ 504 ☐ IEP	Description of Educational Needs/Reason for a 504/IEP (if applicable)	
Previous Schools Attended		

D. YOUTH'S SIBLING INFORMATION

Include any child born to either birthparent *(use additional sheets if needed)*

Sibling 1			
Name (First, Middle, Last)	Gender	Date of Birth/Age	Relation ☐ Full ☐ Maternal ☐ Paternal
City/State	Legal Status (Ex: adopted, guardianship, etc.)	Name of Person Living With and Relationship	
Describe Level of Contact Between the Siblings			

Sibling 2			
Name (First, Middle, Last)	Gender	Date of Birth/Age	Relation ☐ Full ☐ Maternal ☐ Paternal
City/State	Legal Status (Ex: adopted, guardianship, etc.)	Name of Person Living With and Relationship	
Describe Level of Contact Between the Siblings			

Sibling 3			
Name (First, Middle, Last)	Gender	Date of Birth/Age	Relation ☐ Full ☐ Maternal ☐ Paternal
City/State	Legal Status (Ex: adopted, guardianship, etc.)	Name of Person Living With and Relationship	
Describe Level of Contact Between the Siblings			

Sibling 4			
Name (First, Middle, Last)	Gender	Date of Birth/Age	Relation ☐ Full ☐ Maternal ☐ Paternal
City/State	Legal Status (Ex: adopted, guardianship, etc.)	Name of Person Living With and Relationship	
Describe Level of Contact Between the Siblings			

Sibling 5			
Name (First, Middle, Last)	Gender	Date of Birth/Age	Relation ☐ Full ☐ Maternal ☐ Paternal
City/State	Legal Status (Ex: adopted, guardianship, etc.)	Name of Person Living With and Relationship	
Describe Level of Contact Between the Siblings			

Sibling 6			
Name (First, Middle, Last)	Gender	Date of Birth/Age	Relation ☐ Full ☐ Maternal ☐ Paternal
City/State	Legal Status (Ex: adopted, guardianship, etc.)	Name of Person Living With and Relationship	
Describe Level of Contact Between the Siblings			

E. BIRTH PARENT INFORMATION

If your agency has similar information documented on a different form, you may provide copies of that form to AASK and skip this section, or the birthparent may complete the SFN 930 Birthparent Background Information.

Birth Mother Information

* 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.

Name (First, Middle, Last)		Social Security Number*	Hispanic ☐ Yes ☐ No ☐ Unknown
Native American Name, if applicable		Place of Birth	Date of Birth
Religion	Race	Tribal Affiliation	Enrollment Number
Last Known Address/Location			
Marital Status at time Youth was Born	Current Marital Status	Last Grade/Education Completed	
Past Employment Information			
Present Employment Information			
Physical Description (Ex: height, weight, hair color, eye color, tattoos, etc.)			
Describe Their Personality, Strengths, etc.			

Culture/Traditions Important to the Family
Birth Mother's Medical History (Ex: Diseases, Diagnosis, Surgeries, Medical History, and Mental Health History)
Birth Mother's Alcohol/Drug Usage History
Birth Mother's Extended Family's Medical History (Ex: Diseases, Diagnosis, Surgeries, Medical History, and Mental Health History)
Birth Mother's Extended Family's Alcohol/Drug Usage History

Birth Mother's Parent Information *(Youth's Maternal Grandparents)*		
Birth Mother's Parents' Name	Gender	Living ☐ Yes ☐ No If No, Cause of Death
Reason they are ruled out as an adoption option (if applicable)		
Birth Mother's Parents' Name	Gender	Living ☐ Yes ☐ No If No, Cause of Death
Reason they are ruled out as an adoption option (if applicable)		

Birth Mother's Siblings Information *(Youth's Maternal Aunts and Uncles)*		
Birth Mother's Sibling's Name	Gender	Living ☐ Yes ☐ No If No, Cause of Death
Reason they are ruled out as an adoption option (if applicable)		
Birth Mother's Sibling's Name	Gender	Living ☐ Yes ☐ No If No, Cause of Death
Reason they are ruled out as an adoption option (if applicable)		
Birth Mother's Sibling's Name	Gender	Living ☐ Yes ☐ No If No, Cause of Death
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Birth Mother's Sibling's Name	Gender	Living ☐ Yes ☐ No If No, Cause of Death
Reason they are ruled out as an adoption option (if applicable)		
Birth Mother's Sibling's Name	Gender	Living ☐ Yes ☐ No If No, Cause of Death
Reason they are ruled out as an adoption option (if applicable)		

Add another page if additional room is needed.

Birth Father Information

* 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.

Name (First, Middle, Last)		Social Security Number*	Hispanic ☐ Yes ☐ No ☐ Unknown
Native American Name, if applicable		Place of Birth	Date of Birth
Religion	Race	Tribal Affiliation	Enrollment Number
Last Known Address/Location			
Marital Status at time Youth was Born	Current Marital Status	Last Grade/Education Completed	
Past Employment Information			
Present Employment Information			
Physical Description (Ex: height, weight, hair color, eye color, tattoos, etc.)			
Describe Their Personality, Strengths, etc.			
Culture/Traditions Important to the Family			
Birth Father’s Medical History (Ex: Diseases, Diagnosis, Surgeries, Medical History, and Mental Health History)			
Birth Father’s Alcohol/Drug Usage History			
Birth Father's Extended Family’s Medical History (Ex: Diseases, Diagnosis, Surgeries, Medical History, and Mental Health History)			
Birth Father’s Extended Family’s Alcohol/Drug Usage History			

Birth Father's Parent Information *(Youth's Paternal Grandparents)*		
Birth Father's Parents' Name	Gender	Living ☐ Yes ☐ No If No, Cause of Death
Reason they are ruled out as an adoption option (if applicable)		
Birth Father's Parents' Name	Gender	Living ☐ Yes ☐ No If No, Cause of Death
Reason they are ruled out as an adoption option (if applicable)		
Birth Father's Siblings Information *(Youth's Paternal Aunts and Uncles)*		
Birth Father's Sibling's Name	Gender	Living ☐ Yes ☐ No If No, Cause of Death
Reason they are ruled out as an adoption option (if applicable)		
Birth Father's Sibling's Name	Gender	Living ☐ Yes ☐ No If No, Cause of Death
Reason they are ruled out as an adoption option (if applicable)		
Birth Father's Sibling's Name	Gender	Living ☐ Yes ☐ No If No, Cause of Death
Reason they are ruled out as an adoption option (if applicable)		
Birth Father's Sibling's Name	Gender	Living ☐ Yes ☐ No If No, Cause of Death
Reason they are ruled out as an adoption option (if applicable)		
Birth Father's Sibling's Name	Gender	Living ☐ Yes ☐ No If No, Cause of Death
Reason they are ruled out as an adoption option (if applicable)		

Add another page if additional room is needed.

F. PLACEMENT HISTORY

Placement's Name	Town/State	Type of Placement (FC, PATH, Relative, Kin)	Start Date	End Date	Reason for Move

Add another page if additional room is needed.

G. CURRENT PLACEMENT

If the youth is currently placed in a foster home				
Name (First, Last) for Provider 1	Phone Number for Provider 1	Name (First, Last) for Provider 2	Phone Number for Provider 2	
Email Address for Provider 1		Email Address for Provider 2		
Address		City	State	ZIP Code
Is this a relative placement? ☐ Yes ☐ No				
If the youth is currently residing in a facility				
Name of Facility		Facility Case Manager's Name		
Address		City	State	ZIP Code
Telephone Number	Email Address			

H. PERMANENCY PLANNING

Name of Identified Adoptive Family			Is this a relative placement? ☐ Yes ☐ No
If different from the current foster provider, complete the following regarding the identified adoptive family			
Name (First, Last) for Provider 1	Phone Number for Provider 1	Name (First, Last) for Provider 2	Phone Number for Provider 2
Email Address for Provider 1		Email Address for Provider 2	
Address		City	State	ZIP Code

If adoption recruitment is needed, complete the following

Type of Recruitment Services

☐ Wendy's Wonderful Kids (WWK)* ☐ General Recruitment ☐ Both WWK and General Recruitment

*If WWK is chosen, the Team must allow the WWK Recruiter to reach out to relatives that may have been previously ruled out.

Recruitment methods, which allows AASK, a program of Catholic Charities North Dakota, to release non-identifying information regarding the named child, including photographs, filming, and/or videoing for the purposes of adoption recruitment. This release remains in effect indefinitely until adoption finalization or the custodian revokes recruitment in writing to the AASK Specialist.

- ☐ AASK Recruitment Fliers
- ☐ AASK Facebook Page
- ☐ Connect Our Kids Tool (www.connectoutkids.org)
- ☐ The Reel Hope Project, including their website and social media
- ☐ AASK Heart Times Newsletter
- ☐ Adopt Us Kids (www.adoptuskids.org)
- ☐ Adopt America Network (www.adoptamericanetwork.org)
- ☐ Other (specify): _____
- ☐ AASK Website (www.aasknd.org)
- ☐ ND Heart Gallery (an additional ROI is required)
- ☐ A Family for Every Child (www.afamilyforeverychild.org)
- ☐ Other (specify): _____

Approval to accept inquiries from families who do not have an approved adoption home assessment? ☐ Yes ☐ No

If the child does not currently know their permanency plan, describe the plan for notifying the child of their recruitment plan (when, who, how, additional supports needed):

I. ACKNOWLEDGEMENTS

Catholic Charities North Dakota Acknowledgment of Privacy Notice

By signing this document, the custodial agency acknowledge that Catholic Charities North Dakota (CCND) has provided a copy of the agency's HIPAA Notice of Privacy Practices, which explains how the youth's health information will be handled in various situations, and that CCND has allowed the custodial agency the opportunity to discuss any concerns or questions about the privacy of the client's health information. Please contact your CCND worker with any questions or concerns related to the privacy of the client's health information. A copy of the HIPAA Notice of Privacy Practices can be located at www.catholiccharitiesnd.org.

AASK Program Release

The custodial agency understands the AASK adoption process is through CCND, a private licensed child-placing agency under contract with the North Dakota Department of Health and Human Services. The custodial agency is aware that the CCND AASK Program contracts AASK Adoption Services with Building Forever Families and All About U Adoptions, both licensed child placing agencies in North Dakota. The custodial agency understands that any and all information received regarding the above-mentioned child may be shared with applicable agencies including, CCND, Building Forever Families, All About U Adoptions, North Dakota Human Service Zones, North Dakota Tribes, and the North Dakota Department of Health and Human Services for the purposes of the adoption assessment, placement, and planning, as well as for any future follow-up. The custodial agency authorized CCND/AASK to release any and all information regarding the referred child to the other agencies in the AASK partnership.

Catholic Charities North Dakota Acknowledgement of Client Rights and Responsibilities

By signing this form, the custodial agency acknowledges that CCND has provided a copy of the agency's Client Rights and Responsibilities document, which outlines the rights and responsibilities as a client receiving services through CCND. The Client Rights and Responsibilities document also outlines the procedures for filing a formal complaint to initiate the grievance process with the agency. Should there be a concern regarding the services provided by CCND, first discuss the issue with the assigned worker and/or the worker's supervisor. If this does not resolve the concern, please follow the procedure as outlined in the Client Rights and Responsibilities document to file a formal complaint. A copy of the Client Rights and Responsibilities can be located at www.catholiccharitiesnd.org.

As a representative of the custodial agency, my signature below indicates that I have read and acknowledged the CCND Acknowledgement of Privacy Practice Notice, AASK program release, and CCND Acknowledgement of Client Rights and Responsibilities document which also includes the formal grievance process for Catholic Charities North Dakota.

J. SUPPLEMENTAL INFORMATION REQUIRED

The following documentation must be submitted to AASK. If the following documents are not submitted to AASK within twelve (12) months of the initial referral OR within six (6) months of the termination of parental rights/suspension of parental rights order, AASK has the right to close the Tribal Referral.

- ☐ Verification of Tribal Enrollment
- ☐ Relative Search Documentation
- ☐ Birth Certificate (certified needed if outgoing ICPC)
- ☐ SFN 927 Caregiver Summary
- ☐ Lifebook and/or Photos of the Youth
- ☐ AASK Authorization (last page of referral)
- ☐ Court Documentation
- ☐ SFN 869 - Only for outgoing ICPC cases
  - ☐ Shelter Care/Initial Removal Order/Affidavit for Removal
  - ☐ Affidavit for Termination of Parental Rights/Suspension of Parental Rights
  - ☐ Termination of Parental Rights Order/Suspension of Parental Rights
  - ☐ All Other Court Documentation

Submit the following items when AASK becomes active in the case

- ☐ SFN 793 Adoption Assistance Documentation of Need
- ☐ SFN 854 Title IV-E Adoption Subsidy Certification

K. CUSTODIAL AGENCY INFORMATION

Case Manager's Name (Print)	Telephone Number
Email Address	
Case Manager's Signature	Date

Agency

- ☐ Standing Rock Sioux Tribe CPS
- ☐ MHA Nation Children and Family Services
- ☐ Turtle Mountain Child Welfare
- ☐ Spirit Lake Tribal Social Services

Send the completed Tribal Exception Referral for AASK Services to: AASKreferrals@catholiccharitiesnd.org

ADULTS ADOPTING SPECIAL KIDS PROGRAM (AASK)
AUTHORIZATION TO DISCLOSE INFORMATION

AASK Contact Name		AASK Agency Telephone Number	
AASK Agency Address	City	State	ZIP Code

This form is used by authorized agents to permit the disclosure of records and information to the AASK Program for adoption purposes.

Directions authorized agent: Complete and sign the form. Retain a copy in the child's case record. Return the completed form along with a copy of the current court order indicating your authority to act on behalf of the child to the above AASK location.

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CHILD'S RECORDS TO BE DISCLOSED

Child's Name (Last, First, Middle)	Social Security Number*	Date of Birth
Other Names Used		

I authorize:

- All medical sources including but not limited to hospitals, clinics, occupational therapy, physical therapy, optometrists, dentists, and labs.
- All Behavioral Health sources including but not limited to mental health, psychological, psychiatric, and substance use disorder;
- All Development, Education and Vocational sources including but not limited to schools, special education, teachers, administrators and counselors, speech therapists, Developmental Disability service providers, and Vocational Rehabilitation; and
- Foster care personnel and providers.

To mutually exchange with the AASK Program, the following information:

- All medical and treatment records including but not limited to: Preventive, diagnostic, therapeutic, rehabilitative, and counseling, service, assessment, or procedure with respect to the physical or mental condition, or functional status, of the above name child;
- All education records;
- All Court orders, records, and reports;
- Foster care case plans, goals and progress, family history, and progress in the foster home.

The information will be used for adoption purposes.

This Authorization will expire on (MM/DD/YYYY):

This authorization is voluntary. Your authorization or refusal to authorize disclosure of personal health information will have no effect on your treatment, payment, enrollment, or eligibility for benefits.

This authorization remains in effect until the expiration date unless specifically revoked. You have the right to revoke this authorization at any time, except to the extent that action has already been taken in reliance on it. To revoke, send a written statement to the AASK location above. Unless otherwise agreed in writing, information may be disclosed under this authorization in any form or medium, including verbal, written or electronic transmission. A photocopy of this authorization is as effective as the original.

Except for information protected under the federal regulations governing Confidentiality of Substance Use Disorder Patient Records, 42 C.F.R. Part 2, there is a potential for information disclosed pursuant to this authorization to be subject to re-disclosure by the recipient and no longer protected by state or federal privacy laws.

SUBSTANCE USE DISORDER INFORMATION is protected under the federal regulations governing Confidentiality of Substance Use Disorder Patient Records, 42 C.F.R. Part 2, and cannot be disclosed without written consent unless otherwise provided for in the regulations. In accordance with North Dakota law, the signature of a minor 14 years of age or older is required to disclose substance use disorder information. Both the signature of a minor 13 years of age or younger and the signature of the minor's legal representative is required to authorize the disclosure of substance use disorder information.

Authorized Agency Name		Telephone Number	
Agency Address	City	State	ZIP Code
Printed Name of Authorized Agent	Title		
Signature of Authorized Agent		Date	
Signature of Child (if required)		Date	