



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

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CHILDREN FAMILY SERVICES-ADOPTIONS
SFN 923 (1-2025)

Directions: ND Tribal Social Services will complete this referral and provide the supplemental information to AASK for the purposes of adoption services. Do not leave boxes blank. Either include "unknown" or "not applicable".

* 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

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

B. HEALTH AND DEVELOPMENT (Partial or incomplete information my result in the referral being denied.)

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 <input type="checkbox"/> Full <input type="checkbox"/> Maternal <input type="checkbox"/> 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 <input type="checkbox"/> Full <input type="checkbox"/> Maternal <input type="checkbox"/> 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 <input type="checkbox"/> Full <input type="checkbox"/> Maternal <input type="checkbox"/> 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. Do not leave blank boxes.

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 <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> 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 and 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 Alcohol/Drug Usage History and Medical History (Ex: Diseases, Diagnosis, Surgeries, Medical History, and Mental Health History)			
Birth Mother's Extended Family's Drug/Alcohol Usage History and Medical History (Ex: Diseases, Diagnosis, Surgeries, Medical History, and Mental Health History)			
Birth Mother's Parent Information (Youth's Maternal Grandparents)			
Birth Mother's Parents' Name	Gender	Living <input type="checkbox"/> Yes <input type="checkbox"/> No	If No, Cause of Death
Reason they are ruled out as an adoption option (if applicable)			
Birth Mother's Parents' Name	Gender	Living <input type="checkbox"/> Yes <input type="checkbox"/> 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 <input type="checkbox"/> Yes <input type="checkbox"/> 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 <input type="checkbox"/> Yes <input type="checkbox"/> 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 <input type="checkbox"/> Yes <input type="checkbox"/> 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 <input type="checkbox"/> Yes <input type="checkbox"/> 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 <input type="checkbox"/> Yes <input type="checkbox"/> 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 <input type="checkbox"/> Yes <input type="checkbox"/> 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. Do not leave boxes blank.

Name (First, Middle, Last)		Social Security Number*	Hispanic <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> 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 and 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 Alcohol/Drug Usage History and Medical History (Ex: Diseases, Diagnosis, Surgeries, Medical History, and Mental Health History)			
Birth Father's Extended Family's Alcohol/Drug Usage History and Medical History (Ex: Diseases, Diagnosis, Surgeries, Medical History, and Mental Health History)			
Birth Father's Parent Information (Youth's Paternal Grandparents)			
Birth Father's Parents' Name		Gender	Living <input type="checkbox"/> Yes <input type="checkbox"/> No If No, Cause of Death
Reason they are ruled out as an adoption option (if applicable)			
Birth Father's Parents' Name		Gender	Living <input type="checkbox"/> Yes <input type="checkbox"/> 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 <input type="checkbox"/> Yes <input type="checkbox"/> 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 <input type="checkbox"/> Yes <input type="checkbox"/> 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 <input type="checkbox"/> Yes <input type="checkbox"/> 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 <input type="checkbox"/> Yes <input type="checkbox"/> 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 <input type="checkbox"/> Yes <input type="checkbox"/> 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 <input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No
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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.

<input type="checkbox"/> AASK Recruitment Fliers	<input type="checkbox"/> AASK Heart Times Newsletter	<input type="checkbox"/> AASK Website (www.aasknd.org)
<input type="checkbox"/> AASK Facebook Page	<input type="checkbox"/> Adopt Us Kids (www.adoptuskids.org)	<input type="checkbox"/> ND Heart Gallery (an additional ROI is required)
<input type="checkbox"/> Connect Our Kids Tool (www.connectoutkids.org)	<input type="checkbox"/> Adopt America Network (www.adoptamericanetwork.org)	<input type="checkbox"/> Other (specify): _____
<input type="checkbox"/> The Reel Hope Project, including their website and social media	<input type="checkbox"/> News Outlets and Segments	

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):

Custodial authorization for family review of child information:

I hereby authorize AASK to share child specific information from the AASK file with any inquiring prospective adoptive family.

☐ Yes ☐ No - AASK will request individual family authorization on a case-by-case basis.

Custodial Representative Signature	Authorization End Date	Date Signed
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I. ACKNOWLEDGEMENTS

Catholic Charities North Dakota Acknowledgment of Privacy Notice

By signing this document, the custodial agency acknowledges 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 All About U Adoptions, a licensed child placing agency 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, 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 provided to AASK at the time of submitting the completed SFN 923. The AASK referral will not be accepted without the accompanied supplemental documentation:

- | | | |
|--|--|--|
| <input type="checkbox"/> Verification of Tribal Enrollment | <input type="checkbox"/> Relative Search Documentation | <input type="checkbox"/> Birth Certificate (certified needed if outgoing ICPC) |
| <input type="checkbox"/> Court Documentation | | <input type="checkbox"/> SFN 854 Title IV-E Adoption Subsidy Certification |
| <input type="checkbox"/> Shelter Care/Initial Removal Order/Affidavit for Removal | | <input type="checkbox"/> SFN 793 Adoption Assistance Documentation of Need |
| <input type="checkbox"/> Affidavit for Termination of Parental Rights/Suspension of Parental Rights | | |
| <input type="checkbox"/> Termination of Parental Rights Order/Suspension of Parental Rights, if already granted
(If TPR/Suspension of Parental Rights has not yet occurred at the time of referral, it must be provided to AASK once granted) | | |
| <input type="checkbox"/> All Other Court Documentation | | |

Submit the following as applicable:

- | | | |
|--|--|---|
| <input type="checkbox"/> SFN 927 Caregiver Summary | <input type="checkbox"/> Lifebook and/or Photos of the Youth | <input type="checkbox"/> SFN 869 - Only for outgoing ICPC cases |
|--|--|---|

K. CUSTODIAL AGENCY INFORMATION

Case Manager's Name (Print)	Telephone Number
Email Address	
Case Manager's Signature	Date
Agency <input type="checkbox"/> Standing Rock Sioux Tribe CPS <input type="checkbox"/> MHA Nation Children and Family Services <input type="checkbox"/> Turtle Mountain Child Welfare <input type="checkbox"/> Spirit Lake Tribal Social Services	

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