



REPORT OF ADOPTION/ADOPTIVE PLACEMENT

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CHILDREN AND FAMILY SERVICES-ADOPTIONS
SFN 939 (6-2023)

This form is to be completed and forwarded to the Department within 1 week of adoptive placement.

This section for HHS use only

Child's CCWIPS Case Number	BC Unit Number	Adoptive Family Unit Number
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CHILD DATA

Child's Birth Name		Date of Birth	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female
* Social Security Number	Place of Birth (City, State and Country)		
Race	Hispanic <input type="checkbox"/> Yes <input type="checkbox"/> No	Tribal Enrollment Number	Tribal Affiliation
Child's Former Name(s)		US Citizen <input type="checkbox"/> Yes <input type="checkbox"/> No	

Prior Disrupted Permanent Placements

Was this child previously adopted? <input type="checkbox"/> Yes <input type="checkbox"/> No	Date of Last Finalized Adoption
Was this child adopted from a foreign country? <input type="checkbox"/> Yes <input type="checkbox"/> No	Placing Agency of International Adoption
Prior guardianship before current out-of-home episode? <input type="checkbox"/> Yes <input type="checkbox"/> No	Prior Guardianship Date

* In compliance with the Federal Privacy Act of 1974, the disclosure of the social security number is voluntary and it is requested for identification purpose. Failure to disclose this information will not affect participation in this program.

BIRTH PARENT INFORMATION

	Parent #1	Parent #2
Name		
Social Security Number		
Gender	<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Male <input type="checkbox"/> Female
Race (See Code Table)		
Member of Tribe	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Tribal Affiliation		
Tribal Enrollment Number		
US Citizen	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Hispanic Origin	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Date of Birth		
Birth Place		
Current Marital Status (See Code Table)		
Effective Date (of current marital status)		
Marital Status at time of this child's birth (See Code Table)		

BIRTH PARENT INFORMATION (continued)

	Parent #1	Parent #2
Aliases		
Street Address		
City, State, and ZIP Code		
County		
Telephone Number		
Effective Date of Address		
Parent Status (See Code Table)		

ADOPTIVE PARENT INFORMATION

	Parent #1	Parent #2	
Name			
Social Security Number			
Gender	<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Male <input type="checkbox"/> Female	
Race (See Code Table)			
Member of a Tribe	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
Tribal Affiliation			
Tribal Enrollment Number			
US Citizen	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Hispanic Origin	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Date of Birth			
Birth Place			
Marital Status (See Code Table)			
Effective Date (of marital status)			
Aliases			
Parent(s) Street Address	City	State	ZIP Code
Mailing Address (if different from Street Address)	City	State	ZIP Code
County	Telephone Number		
Effective Date of Address			
Legal Status at Placement (check only one): <input type="checkbox"/> Legal custody - adoptive parent(s) - pursuant to Identified Relinquishment (NDCC 14-15.1) <input type="checkbox"/> Legal custody - NDHHS or HSZ (indicate specific HSZ): _____ <input type="checkbox"/> Legal custody - Out of State Public Agency Specify Agency: _____ <input type="checkbox"/> Legal custody - Tribe Tribe: _____ <input type="checkbox"/> Legal custody - Private LCPA by Court Order Agency Name: _____ <input type="checkbox"/> Guardianship by Court Order to _____ <input type="checkbox"/> Other (specify): _____			
County Court	Termination of Parental Rights (TPR) Date	Indicate if TPR was Voluntary/Involuntary (V-I) on part of birthmother: <input type="checkbox"/> V <input type="checkbox"/> I birthfather: <input type="checkbox"/> V <input type="checkbox"/> I	

ADOPTION/PLACEMENT INFORMATION

Adoption Type (see Code Table)	Formal Adoptive Placement Date	Was the child difficult to place? <input type="checkbox"/> Yes <input type="checkbox"/> No
Child's Full Adoptive Name		
Placing Agency (if Agency Placement)		Involved Agency (if Non-Agency Adoption)
For Native American Children for whom ICWA applies, were placement preferences followed? <input type="checkbox"/> Yes <input type="checkbox"/> No Comments (required for both yes and no answers):		
Was this an adoption by the child's foster parent? <input type="checkbox"/> Yes <input type="checkbox"/> No		Was this an adoption by the child's step parent? <input type="checkbox"/> Yes <input type="checkbox"/> No
Was this an adoption by a biological relative of the child? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes: <input type="checkbox"/> Paternal <input type="checkbox"/> Maternal Specify relationship:		
Was this an adoption by a non-biological/fictive kin of the child (not foster care provider)? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, specify relationship:		
Was this an adoption by a non-related individual? <input type="checkbox"/> Yes <input type="checkbox"/> No	Does this child have siblings? <input type="checkbox"/> Yes <input type="checkbox"/> No	Number of Siblings in the Adoptive Home

International Adoption (if applicable)

Was the TPR/relinquishment done in the foreign country? <input type="checkbox"/> Yes <input type="checkbox"/> No	Custody Given To
Was the adoption finalized in the foreign country? <input type="checkbox"/> Yes <input type="checkbox"/> No	Type of Visa <input type="checkbox"/> IR 3 <input type="checkbox"/> IR 4

Special Needs (as documented on SFN 1084) See codes

Primary SNC	Other SNC	Date Approved
Condition/Disability		

State/Tribal Custody Children

For state/tribal custody children being served by contract agency, were specialized recruitment services utilized? <input type="checkbox"/> Yes <input type="checkbox"/> No
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ADOPTION ASSISTANCE INFORMATION

Start Date	Monthly Amount or MA Only	Is the child IV-E for the purposes of adoption assistance? <input type="checkbox"/> Yes <input type="checkbox"/> No
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The representative of the agency reporting this placement attests to the accuracy of the information provided herein. If this is an agency placement, the agency will provide supervision of the placement until the adoption is finalized and will report the finalization and any disruption in this placement to the Department.

Agency Reporting	Date Reporting
Worker Signature	Supervisor Signature

Code Tables

RACE	PARENT STATUS	SPECIAL NEEDS CRITERIA
AI American Indian/Alaskan Native	AC Acknowledged	AG 7 Years of Age or Older
AP Asian	AD Adoptive	DI Mental, Physical or Emotional Disability
BL Black or African American	AL Adjudicated/Legal	RO Racial/Original Background
HP Native Hawaiian/Pacific Islander	BI Biological	SG Sibling Group Placed Together
WH White	NA Named/Alleged	HR At High Risk as Diagnosed by Physician
	PP Presumed/Putative	

MARITAL STATUS	ADOPTION TYPE	SPECIAL NEEDS/SPECIFIC CONDITIONS/DISABILITY
DI Divorced	FO Foreign Adoption	ED Emotional Disturbance
MA Married	ID Identified	MR Mental Retardation
NM Never Married	IR Infant/Regular	OT Other
RE Remarried	RE Relative	PD Physical Disability
SE Separated	SN Special Needs	VH Visual/Hearing Impaired
UN Unable to Determine		
WI Widowed		

Distribution: Original to Department, Copy to be kept in LCPA file