SUBSIDIZED GUARDIANSHIP CONTINGENT APPROVAL REQUEST

ND DEPARTMENT OF HUMAN SERVICES/CFS

SFN 1834 (Rev. 02-2001)

Clear Fields

Social Worker/Agency:			
Child's Name:	Date of Birth:	Sex:	Social Security Number:
Address:	City:	State:	Zip Code:
Child in continuous foster care since:	Date guardianship discussed at perm plan:		Date of last permanency hearing:
Name of Mother:	Name of Father:		
Status of Parental Rights: TPR ☐ Yes ☐ No	Status of Parental Rights: TPR ☐ Yes ☐ No		

(Attach copy of current court order/relinquishment.)

Name of Prospective Guardian(s):			Phone Number:
Address:	City:	State:	Zip Code:
Relationship to child, i.e. foster parent(s), aunt, grandparent, etc.:			
Prospective guardian(s) is a resident of North Dakota? ☐ Yes ☐ No			Resident of:

SECTION I.

☐ Yes ☐ No Has a compelling reason been determined that filing a petition to terminate parental rights would not be in the child's best interest? (Attach copy of SFN 348)

☐ Yes ☐ No Are foster care payments being made on behalf of the child?

☐ Yes ☐ No Have biological parents given consent to guardianship?

☐ Yes ☐ No If not, will biological parents give consent to guardianship?

☐ Yes ☐ No Is child covered under a medical plan? If yes, source of coverage _____

☐ Yes ☐ No Will guardian's medical insurance cover child? If not, source of medical coverage following guardianship. _____

SECTION II.

Child's Income/Assets:	**Amount/Value**
Checking/Savings	
Stocks/Bonds	
Vehicle	
SSI/SSA/VA benefits*	
IRA/CD	
Real Estate	
Life Insurance	
Other	

CFS Use Only:	
Guardianship subsidy	
Subtract any other monthly benefit	
Total monthly subsidy (reference only - paid on daily rate)	

* Indicate if eligible but not presently receiving payment. (Income & assets will be considered when determining monthly guardianship subsidy.)

Prospective Guardian:	Date:
Prospective Guardian:	Date:
Custodian:	Date:
County Director:	Date:
Regional Supervisor:	Date:

Contingent approval in effect for six months following department signature date.

☐ Approved	Monthly Subsidy Amount: $
☐ Denied	Denial Reason:
Signature By: (Children & Family Services - Department of Human Services)	Date:

The Privacy Act of 1974 (P.L. 93-579, Section 7) requires the following information be provided when individuals are requested to disclose their social security numbers. 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 - CFS **Copies** to Prospective Guardian(s), County Director, Regional Supervisor, Custodian