Reset Form

Ohio Department of Job and Family Services
Application for State Adoption Subsidy

(Completion of this form is required for the agency to proceed with a state adoption maintenance subsidy and a recommendation for medical coverage)

PURPOSE

The purpose of the Application for State Adoption Subsidy (JFS 01613) is to allow adoptive families who have an adoptive child with special needs to apply for financial assistance. This form also allows adoptive families to present information/verification of their child's special needs for medical, mental health or rehabilitative care in an effort to obtain a recommendation for Title XIX medical assistance.

The following information is needed from you before a determination can be made regarding your application for a state adoption subsidy: The JFS 01613 "Application for State Adoption Subsidy;" JFS 01654 "Adoptive Placement Agreement," if applicable, JFS 01685, "Child Study Inventory (CSI) facesheet with the child study inventory attached, financial verification, and any other information that may help in determining your financial needs and the special needs of your child (i.e., financial statements, medical statements, case history information, or other pertinent analysis by a licensed professional such as a physician, psychologist, psychiatrist, social worker, counselor, or nurse).

SECTION I: AGENCY INFORMATION

Name of Public Children Services Agency:	Date of Application:
Agency Street Address, City, State and Zip Code:	Telephone Number: ( )

Name of Custodial Agency *(If different than above)*:	Contact Person:
Agency Street Address, City, State and Zip Code	Telephone Number: ( )

SECTION II: ADOPTIVE PARENT(S)

Name of Adoptive Father: *(first and last)*	Name of Adoptive Mother: *(first and last)*
Adoptive Family Street Address, City, State and Zip Code:	Telephone Number: ( )

I/We are interested in: ***(Check all that apply)***

☐ *State Adoption Maintenance Subsidy* - (subsidy payments to assist adoptive parents)

☐ *Covered Families and Children Medicaid* - (medical coverage for adoptive child with special needs for medical, mental health, or rehabilitative care)

SECTION III: ADOPTIVE CHILD

Child's Adoptive Name: *(first and last)*	Date of Birth:	Sex: ☐ Male ☐ Female

Race of Adoptive Child:

☐ Asian ☐ Black/African American ☐ Hawaiian/Pacific islander

☐ American Indian/Alaskan Native ☐ Bi-racial ☐ White

Ethnicity of Adoptive Child:

☐ Hispanic/Latino

Date of Actual or Anticipated Adoptive Placement:

Description of Adoptive Child's Special Need(s) for Purposes of State Adoption Subsidy:

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SECTION IV: SUBSIDY REQUEST

What kind of financial assistance are you requesting? _____

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What kind of medical assistance are you requesting? _____

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SECTION V: YOUR RIGHT TO A STATE HEARING

Upon receipt of your state adoption application packet, the agency will make a determination for a state adoption maintenance subsidy and a determination of your child's special needs for medical, mental health, or rehabilitative care.

If, after the agency's determination, you do not agree with the action taken, you have a right to a state hearing. For a complete explanation of your hearing rights and the hearing process, please read "Explanation of State Hearing Procedures," JFS 04059. A copy of the JFS 04059 should be given to you along with this application form.

SECTION VI: ADOPTIVE PARENT(S) SIGNATURE

I affirm that the information given in this application is accurate. I understand that verification of my financial situation will be required. I affirm that the financial documentation provided is true and accurate. I acknowledge that approval is contingent upon the availability of funds.

In accordance with section 2921.13 of the Ohio Revised Code, it is a misdemeanor of the first degree to knowingly falsify statements when the statement is made to secure benefits administered by a governmental agency or paid out of a public treasury.

Signature of Adoptive Father:	Date:
Signature of Adoptive Mother:	Date:

Instructions for Completing the JFS 01613 "Application for State Adoption Subsidy"

SECTION I: ***Agency Information***

Name of Public Children Services Agency (PCSA), Address, and Telephone Number: Enter the agency name, address, telephone number, and agency contact person.
Name of Custodial Agency *(If different than above)*: Enter the name of the agency which has permanent custody of the child.
Address, Contact Person, and Telephone Number: Enter the custodial agency's address, contact person, and telephone number.

SECTION II: ***Adoptive Parent(s)***

Name of Adoptive Father: Enter the first and last name of the adoptive father.
Name of Adoptive Mother: Enter the first and last name of the adoptive mother.
Adoptive Family Address and Telephone Number Enter the adoptive family's address and telephone number.
State Adoption Maintenance Subsidy/Covered Families and Children Medicaid: Identify the service(s) for which you are applying.

SECTION III: ***Adoptive Child***

Child's Adoptive Name: Enter the first and last adoptive name of the adoptive child.
Date of Birth: Enter the adoptive child's date of birth.
Sex: Enter the adoptive child's gender.
Race of Adoptive Child: Check the applicable box.
Ethnicity of Adoptive Child: Check this box if the adoptive child is of Hispanic/Latino descent
Date of Actual or Anticipated Adoptive Placement: List the date the adoptive child has been/will be placed in your home for adoptive placement
Description of the Adoptive Child's Special Need(s) for Purposes of State Adoption Subsidy: As outlined in rule 5101:2-44-06 of the Administrative Code, list any special needs the adoptive child has which may include but is not limited to the following: the child is in a sibling group which should be placed together; is a member of a minority or ethnic group; is six years of age or older, has remained in the permanent custody of a public children services agency (PCSA) or private child placing agency (PCPA) for more than one year; has a medical condition, physical impairment, mental retardation or developmental disability; has an emotional disturbance or behavioral problem; has a social or medical history or the background of the child's biological family has a social or medical history which may place the child at risk of acquiring a medical condition, a physical, mental or developmental disability or an emotional disorder; has been in the home of his/her prospective adoptive parents as a foster child for at least one year and would experience severe separation and loss if placed in another setting due to his/her significant emotional ties with these foster parents as determined and documented by a qualified mental health professional; or, has experienced previous adoption disruption or multiple placements .

SECTION IV: ***Subsidy Request***

What kind of financial assistance are you requesting? How will the financial assistance help you? What is the amount per month of financial assistance you are requesting?
What kind of medical assistance are you requesting? What are the medical needs of your child?

SECTION V: ***Your Right to a State Hearing***

This section informs the you of your right to request a state hearing if the you do not agree with the decision made by the agency.

SECTION VI: ***Adoptive Parent(s) Signature***

This is a written statement which confirms the information given in this application is accurate and acknowledges you are aware that you will be required to provide verification of your financial situation.

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