



INDIANA GUARDIANSHIP ASSISTANCE PROGRAM APPLICATION

TITLE IV-E GUARDIAN ASSISTANCE PROGRAM (GAP) OR STATE GUARDIANSHIP ASSISTANCE PROGRAM (SGAP)

State Form 55129 (R2 / 9-14)
DEPARTMENT OF CHILD SERVICES

INSTRUCTIONS: Within ten (10) days of determining that Guardianship is the appropriate permanency plan for the child, return this form to the child's Family Case Manager who will submit it, along with the qualifying results of the background checks completed for each household member, to the Central Eligibility Unit (CEU) for a final eligibility determination. One application per child should be submitted to CEU.

Current name of child		Alias	
DCS Person Identification number of child		Date of birth of child (month, day, year)	Age of child
Name of Prospective Guardian A (If approved, payments will be made to guardian A.)		Telephone number ()	
Address of Prospective Guardian A (number and street, city, state, and ZIP code)			
Relationship to child (Check the box next to the appropriate relationship. The relationship to the child may be by blood, marriage, or adoption) ☐ Grandparent / Great Grandparent ☐ Aunt / Great Aunt ☐ Uncle / Great Uncle ☐ First or Second Cousin ☐ Adult Sibling ☐ Step-Parent ☐ Other Relative			
Name of Prospective Guardian B		Telephone number ()	
Address of Prospective Guardian B (number and street, city, state, and ZIP code)			
Relationship to child (Check the box next to the appropriate relationship. The relationship to the child may be by blood, marriage, or adoption) ☐ Grandparent / Great Grandparent ☐ Aunt / Great Aunt ☐ Uncle / Great Uncle ☐ First or Second Cousin ☐ Adult Sibling ☐ Step-Parent ☐ Other Relative			
Date of guardianship hearing, if known (month, day, year)			
I/We request the following types of guardianship assistance: ☐ IV-E GAP or SGAP Periodic Payments ☐ Non Recurring Expenses (NRE) \$ _____ (maximum of \$2,000 per child) ☐ To be paid to guardian(s) ☐ To be paid to attorney representing the guardian(s). The guardian(s) hereby authorize the DCS to pay non recurring guardianship expenses directly to the following attorney of record in their guardianship proceeding: _____ ☐ Medicaid – Medical Benefits under Title XIX of Social Security Act. Child is eligible for Medicaid if eligible for IV-E GAP, and if IV-E GAP payments are being made on the child's behalf. Children eligible for state-funded GAP will need a special determination by the Division of Family Resources (DFR) to evaluate the child's medical eligibility. After the guardianship, the child will be covered by private health insurance:			
Name of insurance company		Policy number	Effective date (month, day, year)

OTHER SIBLINGS WHO HAVE A PERMANENCY PLAN OF GUARDIANSHIP WITH THE SAME PROSPECTIVE GUARDIAN			
Name	Date of birth (month, day, year)	Name	Date of birth (month, day, year)

LIST ALL PROSPECTIVE GUARDIAN FAMILY HOUSEHOLD MEMBERS (excluding children listed above)		
Name	Relationship	Date of birth (month, day, year)

LIST ALL PROSPECTIVE GUARDIAN FAMILY HOUSEHOLD MEMBERS (excluding children listed above) (continued)		
Name	Relationship	Date of birth (month, day, year)

PROSPECTIVE GUARDIAN ACKNOWLEDGEMENT	
1. I/We, the undersigned, hereby apply for guardianship assistance from DCS. 2. I/We understand that after the child's guardianship, I/we must apply for any other financial benefits to which the child may be entitled (such as Supplementary Security Income (SSI) or Veterans benefits). 3. I/We understand that the Social Security Administration will reduce dollar for dollar any SSI payments received by the child by any amounts received under the Indiana Guardianship Program (GAP & SGAP) and ongoing eligibility for SSI will be based on the guardian family's income. 4. I/We are unable to obtain guardianship for the child without assistance. 5. I/We have a strong commitment to caring permanently for the child. 6. I/We do solemnly affirm that all statements made in the foregoing application are true, correct and complete to the best of my knowledge and belief under penalty of perjury. 7. I/We have successfully completed a fingerprint, Child Protective Services (CPS), and Sex Offender Registry (SOR) background check. (FCM to attach.) 8. I/We understand this application must be submitted to DCS for final approval, that DCS must determine eligibility and approve this application, that I/we must enter into a guardianship agreement with DCS prior to the court order establishing guardianship, and that the court order establishing guardianship must be submitted to DCS before any benefits may begin.	
Signature of Prospective Guardian A	Date (month, day, year)
Printed name of Prospective Guardian A	
Signature of Prospective Guardian B	Date (month, day, year)
Printed name of Prospective Guardian B	

FOR LOCAL OFFICE USE ONLY – FAMILY CASE MANAGER TO COMPLETE			
GENERAL ELIGIBILITY REQUIREMENTS			
Name of child			
1. Is the child thirteen (13) years of age or older? ☐ Yes ☐ No OR Is the child under age thirteen (13) but considered an eligible sibling who is being placed with the same Prospective Guardian? ☐ Yes ☐ No IF YES: Have DCS and the Prospective Guardian(s) agreed that guardianship is the appropriate permanency arrangement for the sibling? ☐ Yes ☐ No			
2. Is the child living with a Prospective Guardian who meets the relative definition for GAP (See Policy Chapter 14.1.) ☐ Yes ☐ No			
3. Is the child's case plan legal guardianship? ☐ Yes ☐ No			
4. Is reunification or adoption an appropriate permanency option for the child? ☐ Yes ☐ No			
5. Was the child removed from his or her home pursuant to a voluntary placement agreement or as a result of a judicial determination that continuation in the home would be contrary to the welfare of the child? ☐ Yes ☐ No			
6. Does the child demonstrate a strong attachment to the Prospective Guardian(s)? ☐ Yes ☐ No			
7. If the child is thirteen (13) years of age or older, has he/she been consulted regarding the guardianship arrangement? ☐ Yes ☐ No ☐ NA (Check NA only if the child is less than thirteen (13) years of age.)			
8. Is the Prospective Guardian licensed and has the child been placed in the Prospective Guardian's home for at least six (6) consecutive months? ☐ Yes ☐ No			
9. Is the child eligible for IV-E Foster Care Maintenance Payments? ☐ Yes ☐ No			
10. Did the prospective guardian categorized as "Other Relative" have a prior, significant relationship with the child prior to current DCS involvement? ☐ Yes ☐ No			
Name of Family Case Manager	County	Telephone number ()	Fax number ()