Reset Form

APPLICATION FOR CONTINUATION OF GUARDIANSHIP ASSISTANCE AGREEMENT BEYOND AGE EIGHTEEN (18)
For Recipients of Title IV-E Guardianship Assistance Program (GAP-Older Youth)

State Form 55156 (R / 6-19)
DEPARTMENT OF CHILD SERVICES

INSTRUCTIONS:
Continuation of periodic payments and/or Medicaid may be available for a child whose Title IV-E guardianship assistance (GAP) finalized on after the child's 16th birthday. The guardian should complete this application, and obtain the additional required documentation described below. The application and paperwork must be submitted to the Department of Child Services Central Eligibility Unit (CEU) thirty (30) days prior to the child's 18th birthday. The Department will review the submitted documentation to determine if the child qualifies for a continuance of guardianship assistance and/or Medicaid beyond the age of eighteen (18) for a child whose guardianship assistance finalized on after the child's 16th birthday. Submission of this paperwork does not guarantee continuation of benefits; all cases are reviewed individually, and determinations are made based on set criteria. The guardian should return the completed application and supporting documentation to CEU by fax at (317) 234-4547, email to Centralized.Eligibility@dcs.IN.gov or mail to:
Indiana Department of Child Services - Central Eligibility Unit – *100 N Senate Ave, RM N848, MS-48, Indianapolis, IN 46204*

Name of child	Person identification	Date of birth of child *(month, day, year)*
Name of guardian A	Name of guardian B	

Your child currently receives Title IV-E GAP periodic payments and Medicaid benefits. To apply for a continuation of these benefits, you must provide CEU with the following:

- ☐ **A completed 'Application for Continuation of Guardianship Assistance Agreement Beyond Age 18'** *(this document)*
- ☐ **A completed 'Medical Information Form for Continuation of Guardianship Assistance Benefits'** *(attached)*
- ☐ At least ONE (1) of the following:
  - ☐ **Proof of enrollment in a private or public institution** (including high school or a program leading to an equivalent credential like a GED, college, university, technical school or vocational school): A guardian's statement is not sufficient; this document must be issued by the institution (e.g., letter from the office/registrar on letterhead, proof of tuition payment, current course schedule, etc.). The documentation provided must show that enrollment in a private or public institution is expected to continue beyond the child's 18th birthday.
  - ☐ **Supporting documentation of employment or participation in a program to promote employment:** Submit documentation of the number of hours the child is employed a month or documentation of the child's participation in a program or activity that promotes or is designed to remove barriers to employment, including Job Corps or attendance in classes on resume writing and interview skills.
  - ☐ **Supporting documentation of a medical condition:** Submit supporting documentation, if available, such as an Individual Education Plan (IEP) or other documentation that demonstrates the impact of the child's medical condition on daily functioning and how the condition impacts the child's ability to be enrolled in a private or public institution, be employed, or participate in a program to promote employment.

I / We authorize the Indiana Department of Child Services to request an independent examination and report from a qualified professional selected by the DCS in order to assist DCS in its decision regarding this request for continuation.

I / We certify that we are legally and financial responsible for the above named child and I / We are entitled to claim the child as a dependent for federal and state income tax purposes.

I / We understand that this application and required documentation must be completed and returned to the DCS at least 30 days prior to the child's 18th birthday.

I / We hereby apply for continuation of the guardianship assistance agreement and Medicaid on behalf of the child listed above and I/We maintain that all statements and attached documents are accurate and true

Signature of guardian A	Date signed *(month, day, year)*
Signature of guardian B	Date signed *(month, day, year)*
Signature of child	Date signed *(month, day, year)*
Mailing address *(number and street, city, state, and ZIP code)*	
Telephone number ( )	E-mail address

MEDICAL INFORMATION FOR CONTINUATION OF GUARDIANSHIP ASSISTANCE BENEFITS

Part of State Form 55156 (R / 6-19)
DEPARTMENT OF CHILD SERVICES

INSTRUCTIONS:
This form must be completed and signed by the licensed physician, licensed psychiatrist, or licensed psychologist that treats the child. This form must be submitted, along with the 'Application for Continuation of Guardianship Agreement Beyond Age 18' and any supporting documentation, to the Department of Child Services Central Eligibility Unit (CEU) thirty (30) days prior to the child's 18th birthday by fax at (317) 234-4547, email at Centralized.Eligibility@dcs.IN.gov or mail to:
***Indiana Department of Child Services - Central Eligibility Unit -** 100 N Senate Ave. Room N848, MS-48, Indianapolis, IN 46204*

Name of child	Date of birth of child *(month, day, year)*
Date child first seen by your office *(month, day, year)*	Date child last seen by your office *(month, day, year)*

Frequency of visits: ☐ Weekly ☐ Monthly ☐ Every _____ Months ☐ Annually ☐ Other: _____

CURRENT DIAGNOSED MEDICAL CONDITIONS

Complete the requested information for each medical diagnosis. Use an additional page if necessary to document all diagnosed conditions.

Diagnosis 1

Diagnosis	DSM-V or ICD-9-CM Code	Date of onset *(month, day, year)*
Frequency of Symptoms: ☐ Cyclical / Episodic ☐ Continuous / Unremitting	Frequency	Severity ☐ Mild ☐ Moderate ☐ Severe ☐ Extreme
Medication	Dosage	
Medication	Dosage	
Medication	Dosage	

Diagnosis 2

Diagnosis	DSM-V or ICD-9-CM Code	Date of onset *(month, day, year)*
Frequency of Symptoms: ☐ Cyclical / Episodic ☐ Continuous / Unremitting	Frequency	Severity ☐ Mild ☐ Moderate ☐ Severe ☐ Extreme
Medication	Dosage	
Medication	Dosage	
Medication	Dosage	

Diagnosis 3

Diagnosis	DSM-V or ICD-9-CM Code	Date of onset *(month, day, year)*
Frequency of Symptoms: ☐ Cyclical / Episodic ☐ Continuous / Unremitting	Frequency	Severity ☐ Mild ☐ Moderate ☐ Severe ☐ Extreme
Medication	Dosage	
Medication	Dosage	
Medication	Dosage	

Diagnosis 4

Diagnosis	DSM-V or ICD-9-CM Code	Date of onset *(month, day, year)*
Frequency of Symptoms: ☐ Cyclical / Episodic ☐ Continuous / Unremitting	Frequency	Severity ☐ Mild ☐ Moderate ☐ Severe ☐ Extreme
Medication	Dosage	
Medication	Dosage	
Medication	Dosage	

MEDICAL INFORMATION FOR CONTINUATION OF GUARDIANSHIP ASSISTANCE BENEFITS *(continued)*

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Describe how the listed diagnoses impact the child's daily level of functioning.

Describe the support or treatment needed required to meet the child's needs.

Signature of Physician	Date signed *(month, day, year)*
Printed name of Physician	Title of Physician