GUARDIANSHIP ASSISTANCE AGREEMENT

State Form 49836 (R3 / 7-06) / CW 0029

Date *(month, day, year)*

In the matter of:

Name of child	Name of guardian	Name of guardian

As the above-named child has met the eligibility criteria for the Assisted Guardianship Program, and as the above-named legal guardian(s) has been determined eligible to receive monthly assistance payments under the Assisted Guardianship Program for the care of the child, the legal guardian(s) and the _____ local Department of Child Services (DCS) office agree to the following:

LEGAL GUARDIAN	LOCAL DCS OFFICE
(1) Apply for appropriate medical insurance coverage, either from a private company or through Medicaid, before or immediately following the creation of the legal guardianship.	(1) Provide appropriate assistance in obtaining medical insurance coverage in a timely fashion.
(2) Assign any rights to receive child support to the Department of Child Services.	(2) Make sure the individual(s) establishing legal guardianship understand this requirement, and assist in making arrangements for the assignment of rights to child support.
(3) Use all monthly payments made under this program for the care of the child.	(3) Make monthly payments of $512 to the guardian(s) of the child in question.
(4) Provide any financial and other information requested by the local DCS office for the purposes of an eligibility redetermination that is to occur at least on an annual basis.	(4) Provide written notice to guardian(s) and child(ren) of a scheduled eligibility determination review at least 60 days prior to the review.
(5) Notify the local DCS office immediately regarding any change of circumstances that would alter the amount of the monthly payment or negate the need for such payments for a significant period of time.	(5) Conduct an eligibility redetermination review in a timely manner; i.e., within 30 days of notification of a change in circumstances that would negate the need for assistance payments to the guardian for a significant period of time.

We, the undersigned, agree to follow the Guardianship Assistance Agreement. We acknowledge receipt of a copy of the Agreement, and we agree that the same shall be reviewed at least annually or more often if necessary.

Name of guardian *(typed or printed)*	Signature of guardian	Date of signature *(month, day, year)*
Name of guardian *(typed or printed)*	Signature of guardian	Date of signature *(month, day, year)*
Name of director or authorized representative *(typed or printed)*	Signature of director or authorized representative	Date of signature *(month, day, year)*

____________________ local Department of Child Services (DCS) office

ANNUAL ELIGIBILITY REDETERMINATION AND GUARDIANSHIP ASSISTANCE AGREEMENT REVIEWS

The annual eligibility redetermination and Guardianship Assistance Agreement review was completed on ________________
Date *(month, day, year)*

Signature of guardian	Signature of guardian
Signature of director or authorized representative	Date of signature *(month, day, year)*

The annual eligibility redetermination and Guardianship Assistance Agreement review was completed on ________________
Date *(month, day, year)*

Signature of guardian	Signature of guardian
Signature of director or authorized representative	Date of signature *(month, day, year)*

The annual eligibility redetermination and Guardianship Assistance Agreement review was completed on ________________
Date *(month, day, year)*

Signature of guardian	Signature of guardian
Signature of director or authorized representative	Date of signature *(month, day, year)*

The annual eligibility redetermination and Guardianship Assistance Agreement review was completed on ________________
Date *(month, day, year)*

Signature of guardian	Signature of guardian
Signature of director or authorized representative	Date of signature *(month, day, year)*

The annual eligibility redetermination and Guardianship Assistance Agreement review was completed on ________________
Date *(month, day, year)*

Signature of guardian	Signature of guardian
Signature of director or authorized representative	Date of signature *(month, day, year)*

The annual eligibility redetermination and Guardianship Assistance Agreement review was completed on ________________
Date *(month, day, year)*

Signature of guardian	Signature of guardian
Signature of director or authorized representative	Date of signature *(month, day, year)*

Termination of Subsidy

A subsidy under the assisted guardianship program may be terminated if:

1. the child turns eighteen (18), or if the child is a full-time student, termination will occur upon the child's nineteenth (19th) birthday;
2. legal custody is awarded to another individual;
3. the child is incarcerated in an adult facility or committed to a juvenile facility for six (6) month, or longer;
4. the child is no longer living in the home;
5. the legal guardian fails to submit annual review information;
6. the child reenters the child welfare system by being placed in out-of-home care;
7. the guardian is no longer providing financial assistance to the child;
8. the child dies;
9. a successor guardian is appointed; or
10. the guardianship is terminated by the court.

Appeal and Fair Hearing

If the applicant(s) does not agree with the determination to terminate the monthly payment under the Assisted Guardianship Program, the applicant(s) has the right to appeal this action and request a fair hearing pursuant to 470 IAC 1-4. A written appeal and request for hearing must be sent to the local Department of Child Services (DCS) office within thirty (30) days of the date that the determination to terminate Assisted Guardianship payments was made. If the applicant(s) is unable to prepare this letter, the local DCS office will assist in the preparation. The local office is required to:

1. act upon the appeal within thirty (30) days of its receipt; and
2. notify the Indiana Family and Social Services Administration, Hearings and Appeals Section, of the existence of the appeal immediately upon receipt.

If the applicant(s) is unable to reach agreement with the local DCS office, the applicant(s) will be given a fair hearing in accordance with 470 IAC 1-4. The Indiana Family and Social Services Administration, Hearings and Appeals Section, will notify the applicant(s) in writing of the date, time and place for the hearing. The hearing will be held in the county from which the Assisted Guardianship subsidy is received. An impartial Administrative Law Judge will conduct the hearing, which is informal and provides an opportunity for parties with standing to present testimony and evidence.

Prior to or at the hearing, the applicant(s) will have the right to examine case materials pertaining to the Assisted Guardianship case at the local DCS office. The applicant(s) may self-represent at the hearing or authorize a representative, such as an attorney, a relative, a friend or other spokesperson to do so. At the hearing, the applicant(s) will have full opportunity to bring witnesses, establish all pertinent facts, advance any arguments and questions or refute any testimony or evidence presented by the Department of Child Services.

Following the hearing, the Administrative Law Judge will make a decision which will be reported to the applicant(s) and to the local DCS office at the same time. If that decision is unsatisfactory to the applicant(s) or to the local DCS office, an agency review may be requested. Information and instructions regarding the agency review process are included with the decision of the Administrative Law Judge.