Reset Form

# INDIANA ADOPTION PROGRAM APPLICATION TITLE IV-E ADOPTION ASSISTANCE PROGRAM (AAP) OR STATE ADOPTION SUBSIDY (SAS)

State Form 54351 (R / 2-14)
DEPARTMENT OF CHILD SERVICES

| For central office use only – CEU will complete | |
|---|---|
| Person ID | Case ID |
| | |

*INSTRUCTIONS: Within ten (10) days of filing the petition for adoption, or earlier, return this form to the child's family case manager who will submit it, along with the qualifying results of the background check completed in the past twelve (12) months, to the Central Eligibility Unit for final eligibility determination.*

| Current name of child | Legal name of child after adoption |
|---|---|
| Date of birth of child *(month, day, year)* | Age of child |
| Name of adoptive parent A *(If approved, payments will be made to adoptive parent A.)* | Telephone number ( ) |
| Address of adoptive parent A *(number and street, city, state, and ZIP code)* | |
| Name of adoptive parent B | Telephone number ( ) |
| Address of adoptive parent B *(number and street, city, state, and ZIP code)* | |
| Date of final adoption hearing, if known *(month, day, year)* | |

I/We request the following types of adoption assistance:

- ☐ AAP or SAS Payment
- ☐ Non Recurring Adoption Expenses $ _____ (maximum of $1,500 per child)
  - ☐ To be paid to adoptive parents
  - ☐ To be paid to attorney representing adoptive parents in adoption. The adoptive parents hereby authorize the DCS to pay non recurring adoption expenses directly to the following attorney of record in their adoption proceeding: _____
- ☐ Medicaid – Medical Benefits under Title XIX of Social Security Act.
  If child to be adopted is only eligible for SAS, documentation must be submitted identifying the child's medical, physical, mental, or emotional condition in order for the child to be determined eligible for Medicaid. Child to be adopted is eligible for Medicaid if eligible for AAP. (Submit documentation with application.)

**OTHER SIBLINGS WHO ARE BEING ADOPTED AT THE SAME TIME (add additional page if necessary)**

| Name | Date of birth *(month, day, year)* | Name | Date of birth *(month, day, year)* |
|---|---|---|---|
| | | | |
| | | | |

**LIST ALL ADOPTIVE FAMILY HOUSEHOLD MEMBERS *(excluding children listed above)***

| Name | Relationship | Date of birth *(month, day, year)* |
|---|---|---|
| | | |
| | | |
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| | | |

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## ADOPTIVE PARENT ACKNOWLEDGEMENT

1. I/We, the undersigned, hereby apply for adoption assistance from DCS.
2. I/We understand that after the child's adoption, 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 Adoption Program and ongoing eligibility for SSI will be based on the adoptive family income.
4. I/We are unable to adopt the child without assistance.
5. 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.
6. I/We have successfully completed a background check completed with the home study or within the last 12 months. (FCM to attach)
7. 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 an adoption agreement with DCS prior to the final adoption decree, and that the Decree of Adoption must be submitted to DCS before any benefits may begin.

| Signature of Parent A | Date *(month, day, year)* |
|---|---|
| | |
| Printed name of Parent A | |
| | |
| Signature of Parent B | Date *(month, day, year)* |
| | |
| Printed name of Parent B | |
| | |

## *FOR LOCAL OFFICE USE ONLY – FAMILY CASE MANAGER TO COMPLETE*

### DOCUMENTATION OF SPECIAL NEEDS

Name of child

1. Child cannot or should not be returned to the home of his/her parents. *(Check all that apply and attach documentation.)*

| Mother: | Father: |
|---|---|
| ☐ TPR or petition for TPR | ☐ TPR or petition for TPR |
| ☐ Deceased | ☐ Deceased |
| ☐ Consents signed | ☐ Consents signed |
| | ☐ Putative father registry |

2. Specific factor or condition preventing adoption without a subsidy *(indicate Yes or No)*:

   Is the child over age 2? ☐ Yes ☐ No

   **OR**

   Is the child under age two (2) but part of a sibling group being adopted by the same parent in which one child is over two (2)? ☐ Yes ☐ No

   **OR**

   Does the child have a physical, mental, or emotional disability that is expected to require continuous or long-term medical treatment? (Attach documentation from a licensed physician, psychiatrist, psychologist.) ☐ Yes ☐ No

3. Reasonable but unsuccessful effort(s) to adopt without a subsidy *(check all that apply)*:
   - ☐ The parents are unwilling to adopt without a subsidy
   - ☐ The child is being adopted by a relative or foster parent with whom there are significant emotional ties
   - ☐ The child has been listed with SNAPS for a minimum of six months

| Name of Family Case Manager | County | Telephone number | Fax number |
|---|---|---|---|
| | | ( ) | ( ) |