GEORGIA DEPARTMENT OF HUMAN SERVICES
NOTIFICATION OF CHANGE IN FOSTER CARE OR ADOPTION ASSISTANCE

☐ **Expedite, Placement change**

Child: **Medicaid #:** **Date:**

Court Order Language "*Reasonable efforts to finalize"*	_____ Judicial determination was made on this date: _____ Date of the court order with the required language is: _____ Judicial determination was **NOT** made because: _____ It was omitted from the court order; _____ The court found that DFCS had **NOT** made "*reasonable efforts*"; _____ The finding was not timely; i.e., within 12 months
Foster Care Placement	_____ Child was placed in a fully approved/licensed facility effective: _____ Name/Address: _____ Child moved to the above placement from another IV-E reimbursable home/facility? ☐ No ☐ Yes* * *To avoid two IV-E payments on the same day(s) of the child's move or concurrent placement, indicate in "Comments" the Name/Address of the prior home/facility and the date(s) of the IV-E payment.* _____ Child placed in a **NON** IV-E approved placement effective***: *** **Complete Living Arrangement section for Continuing Medicaid Determination**
Adoption Assistance	_____ Adoptive placement effective date: _____ Adoption petition filing date: _____ Adoption finalized as of date:
Parental Deprivation	_____ A change occurred in one or more of these "deprivation factors" in the removal home: ☐ Absent parent returned ☐ Parent deceased ☐ Parent disabled/incapacitated ☐ Parent unemployed ☐ TPR/Surrender of parental rights Parent effected by this change: ☐ Father ☐ Mother Effective date:
Income/Resources (child's)	_____ There was a change in the child's income in the amount of $ _____ received from: ☐ SSI ☐ Child Support ☐ VA Benefits ☐ Social Security ☐ Personal earnings ☐ Other (specify): _____ The child acquired resources total valued at : $ _____ Source(s):
Age	_____ This child reaches (or has reached) age 18 on (date)***: *** **Complete Living Arrangement section for Continuing Medicaid Determination.**
Legal Responsibility	_____ Effective Date _____ DFCS no longer has legal responsibility for the child because: ☐ Custody order expired ☐ DFCS was relieved of custody *** ☐ Other (explain): _____ DFCS re-instated its expired order effective (date): *** **Complete Living Arrangement Section for Continuing Medicaid Determination**.
VPA	A judicial determination that continuation in foster care is in the "best interest" of the child: _____ Was obtained from the court within 180 days of placement _____ Was NOT obtained from the court within 180 days of placement. Effective date:
Trial Home Visit	The child's trial home visit exceeded 6 months or the time frame authorized by the court. Effective date:

Living Arrangement	**Living Arrangement**: A Continuing Medicaid Determination (CMD) must be completed for a foster child who leaves DFCS custody to assure that a child who is Medicaid eligible remains Medicaid eligible. Information on household members and their income is required to complete a CMD.

	Child leaving care due to age: New residential address: _____ City: _____ State: _____ Zip: _____ Phone number: Employment name and address: _____ Monthly income amount: RSDI/SSI: _____ Child Support: _____ Wages: _____ Other: Comments: _____ **Relative Placement**: Relative's Name: _____ Relationship to child: _____ DOB: _____ SSN: _____ Monthly Income: _____ Place of Employment: _____ Relative's Name: _____ Relationship to child: _____ DOB: _____ SSN: _____ Monthly Income: _____ Place of Employment: _____ Residential Address: _____ City:_____ State: _____ Zip Code: _____ Contact number: ( ) All persons living in the household and relationship to child: _____ _____ _____ Copy of court order relieving DFCS of custody attached: Y ☐ N ☐
Comments	

SSCM/JPPS signature: _____ **CL#:** _____ **County:** _____

SSCM/JPPS Printed Name: _____ **Telephone No.: ( )**_____