GEORGIA DEPARTMENT OF HUMAN SERVICES
ADOPTION ASSISTANCE MEMORANDUM

DATE: _______________

TO:
- ☐ **Social Services Administration Unit**
- ☐ **Regional Accounting**
- ☐ **Revenue Maximization Unit**

FROM: ___________________ County DFCS

Caseworker:________________________ Telephone #: _________________

Adoptive Parents: ______________________ Address: ____________________________

Child's Birth Name: _______ DOB: _____ Race: ______ Sex: ___ FC Medicaid #: _________ SSN: ________

Child's name as it should appear on Medicaid Card post finalization: ________________________

Date of Finalization: _________ New Medicaid Number: ___________ New Social Security #: ___________

BENEFITS

This child has been approved for adoption assistance benefits. The approval period is _______ through _______.

The child is eligible for the following:

☐ State Funded title IV-B Adoption Assistance: Amount $________ (UAS Code 508)

☐ Title IV-E Adoption Assistance: Amount $________ UAS Code 509)

☐ Non-recurring Adoption Assistance: Amount $________ Month Paid_____ (UAS Code 510)

Child Turning Age 18

Child meets criteria to continue adoption assistance benefits beyond age 18: ☐ Yes ☐ No.

Approval of Adoption Assistance beyond age 18 must be completed within 60 days prior to the child's 18th birth month. If approved, Adoption Assistance benefits shall begin the month immediately following the child's 18th birth month, and <u>must be changed to Title IV-B funds</u>, if not already Title IV-B.

☐ Full time school attendance has been verified and documented. Verification is required each quarter/semester for the child to remain eligible.

Benefits Section Completed by: ____________________________ ___________
Social Services Case Manager Date

Benefits Section Approved by: ____________________________ ___________
Social Services Supervisor Date

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MEDICAID ANNUAL REDETERMINATION

This child continues to receive adoption assistance benefits. ☐ Yes ☐ No

Child receives SSI? ☐ Yes ☐ No Amount of SSI? $_________

Child covered by adoptive parent(s)' insurance? ☐ Yes ☐ No If yes, please provide name of carrier and all identifying group and coverage information. Please provide copy of insurance card if available.

Name of Carrier: _________________________________
Group Number: __________________________________
Identification Number/Member ID: _________________
Policy Holder: ____________________________________

Medicaid Section Completed by: _________________________ ___________
Social Services Case Manager Date

Medicaid Section Approved by: __________________________ ___________
Social Services Supervisor Date

STATUS CHANGE

☐ Family has moved to a new address, which is indicated above.
(If moving out of state, attach 402 with referral)

Effective: __________________
Date

Adoption Assistance Payments should discontinue effective: _____________ Reason _______________

Reasons:
Child does not meet criteria for Adoption Assistance Past Age 18
Child over 18 and no longer in high school or college full-time
Child has reached age 21
Child over 18 and has completed high school or college
Child deceased
Adoptive parent(s) deceased
Verification of family's legal and financial responsibility cannot be established
Disruption/Dissolution

Status Change Section Completed by: ____________________________ ___________
Social Services Case Manager Date

Status Change Section Approved by: ____________________________ ___________
Social Services Supervisor Date