Ohio Department of Job and Family Services

APPLICATION FOR POST ADOPTION SPECIAL SERVICES SUBSIDY

SECTION I: AGENCY INFORMATION	
Name of Public Children Services Agency	Date of Application

SECTION II: FAMILY DATA		
Name of Adoptive Father *(first and last)*	Name of Adoptive Mother *(first and last)*	
Home Address	City, State and Zip Code	Telephone Number ( )
Number of dependent children in home Adopted Biological Other		Annual Family Income

SECTION III: CHILD DATA		
Last Name of Adoptive Child	First Name of Adoptive Child	Date of Birth
Sex ☐ Male ☐ Female	Date Adoption Finalized	Was the child adopted by a relative? ☐ Yes ☐ No
Type of Adoption ☐ Attorney ☐ International ☐ Private ☐ Public		
Briefly describe your child's physical/developmental handicap or mental/emotional condition **and** attach a statement from a qualified professional.		

SECTION IV: SERVICES AND/OR THERAPEUTIC TECHNIQUE(S) REQUESTED

THERAPEUTIC TECHNIQUE(S) REQUESTED

These therapies address behavioral, emotional or other mental health issues *(Check all that apply)*

Type of Therapy	Name of Provider	Licensing Board	Cost of Service(s)
☐ Psychiatric Counseling			$
☐ Psychological Counseling			$
☐ Substance Abuse Counseling			$
☐ Other *(Specify)*			$
☐ Other *(Specify)*			$

OTHER SERVICES REQUESTED	
	$
☐ Occupational Therapy ☐ Physical Therapy ☐ Speech Therapy	$
Respite ☐Medical **($2,400 MAXIMUM)** ☐Mental Health **($2,400 MAXIMUM)** ***(Check all that apply)***	$
Additional Respite ☐ Medical **($2,400 MAXIMUM)** ☐ Mental Health **($2,400 MAXIMUM)** ***(Check all that apply)***	$
☐ Medical Equipment ☐ Surgery	$

OUT OF HOME CARE REQUESTED

Type of Out of Home Care	Name of Treatment Facility	Licensed By	Cost of Service(s)
☐ Residential Treatment ***(EXCLUDING EDUCATIONAL COSTS)***			**$**
☐ In-patient Hospitalization			**$**
☐ Therapeutic Foster Care			**$**
		TOTAL COSTS OF ALL SERVICES REQUESTED	**$**

SECTION V: RESOURCES (Identify all resources explored, including date contacted, and indicate the amount received, if applicable).				
☐ Alcohol and Drug Addiction Board	☐ Yes	☐ No	DATE	$
☐ Alcohol, Drug Addiction and Mental Health (ADAMH)	☐ Yes	☐ No	DATE	$
☐ Family and Children First Council	☐ Yes	☐ No	DATE	$
☐ Medicaid	☐ Yes	☐ No	DATE	$
☐ MR/DD Family Resource Program	☐ Yes	☐ No	DATE	$
☐ Prevention, Retention, Contingency Fund	☐ Yes	☐ No	DATE	$
☐ Private/Family	☐ Yes	☐ No	DATE	$
☐ Public School District	☐ Yes	☐ No	DATE	$
☐ State Adoption Subsidy	☐ Yes	☐ No	DATE	$
☐ Title IV-E Adoption Assistance	☐ Yes	☐ No	DATE	$
☐ Title XX Benefits	☐ Yes	☐ No	DATE	$
☐ Veteran's Benefits	☐ Yes	☐ No	DATE	$
☐ Other	☐ Yes	☐ No	DATE	$
			TOTAL RECEIVED	$

SECTION VI: AFFIRMATION

I have provided the Public Children Services Agency (PCSA) with a copy of **all** of the following documentation:

☐ a clear written statement of my child's special needs;

☐ an assessment and/or evaluation from a qualified professional;

☐ an estimate of the cost of service(s) that will be provided;

☐ updated financial information; and

☐ my public or private insurance policy regarding the services required, if applicable, and eligibility for services under this program.

I affirm, under penalty of perjury, that the information in this application is accurate. I understand that verification of my financial situation will be required. I understand and agree that the PCSA may contact other persons or organizations to obtain the necessary proof of eligibility and level of benefits. I understand that in some instances, I may be asked to give consent to the PCSA to make whatever contacts are necessary to determine eligibility. I consent to the release of this form and supporting documentation to the review committee established under Ohio Administrative Code rule 5101:2-44-13. I acknowledge that approval is contingent upon the availability of state funds for this program.

I understand that as a condition of continued eligibility for PASSS funds I am required to submit a copy of my child's treatment plan within 30 days of the initial visit, completed by the service provider, details the therapeutic intervention(s) that will be provided for the period in which this application is in effect.

I understand that my application will be reviewed within twenty days after the close of each quarter during the state fiscal year (SFY) in which it was approved. If the results of this review determine that the approved funds have not been utilized, I will be notified by the PCSA, within five days of the review, of their intent to release these funds. I will have twenty days from that notification to produce any outstanding invoices for that quarter. If I do not submit the invoices to the PCSA within the twenty days, the funds will be released to the Ohio Department of Job and Family Services and I will be financially responsible for any outstanding balances in these invoices.

Signature of Adoptive Father	Date	Signature of Adoptive Mother	Date

RIGHT TO A STATE HEARING: You have a right to a state hearing before the Ohio Department of Job and Family Services if your application is denied or if you disagree with any other actions taken on your application. For a complete explanation of your hearing rights and the hearing process, please read "Explanation of State Hearing Procedures," JFS 04059. A copy of the JFS 04059 should be given to you along with this application form.

COMPLETION OF THIS FORM IS REQUIRED FOR THE ESTABLISHMENT OF A POST ADOPTION SPECIAL SERVICES SUBSIDY.