Reset Form

Ohio Department of Children and Youth

APPLICATION FOR POST ADOPTION SPECIAL SERVICES SUBSIDY

SECTION I: AGENCY INFORMATION	
OhioKAN Navigator OhioKAN Region (For Agency Use)	Date of Application

SECTION II: FAMILY INFORMATION		
Name of Adoptive Parent	Name of Adoptive Parent	
Home Address	City, State and Zip Code, County	Telephone Number
Number of dependent children in home Adopted Biological Other	Annual Family Income	

SECTION III: CHILD INFORMATION		
Last Name of Adopted Child	First Name of Adopted Child	Date of Birth
Gender ☐ Male ☐ Female	Date Adoption Finalized	Was the child adopted by a step-parent? ☐ Yes ☐ No If Yes, not eligible for PASSS
Type of Adoption ☐ Attorney/Independent ☐ International ☐ Private Agency ☐ Public Agency		
Briefly describe your child's physical/developmental disability or mental/emotional condition, why the service is needed and is beyond current available financial resources. Attach a statement from a qualified professional describing the child's disability or condition.		

SECTION IV: SERVICES REQUESTED

THERAPEUTIC TECHNIQUE(S) REQUESTED
(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/Hearing Therapy ☐ Chiropractic Services ☐ Vision 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 ☐ Other	$

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			$
☐ Treatment Foster Care			$

SECTION V: RESOURCES (Identify all resources explored, including date contacted, and indicate the amount received, if applicable).	
☐ Alcohol, Drug Addiction and Mental Health (ADAMH) DATE	$
☐ Family and Children First Council DATE	$
☐ Medicaid/OhioRise DATE	$
☐ DODD Family Resource Program DATE	$
☐ Prevention, Retention, Contingency Fund DATE	$
☐ Private/Family DATE	$
☐ Public School District DATE	$
☐ State Adoption Subsidy DATE	$
☐ Title IV-E Adoption Assistance DATE	$
☐ Title XX Benefits DATE	$
☐ Veteran's Benefits DATE	$
☐ Other DATE	$
TOTAL RECEIVED	$
TOTAL COSTS OF ALL SERVICES REQUESTED	**$**

SECTION VI: AFFIRMATION

I have provided 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, including most recent 1040; 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 other persons or organizations may be contacted 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 make whatever contacts necessary to determine eligibility. 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 that details the therapeutic intervention 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 within five days of the review of the 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 within the twenty days, the funds will be released to the Ohio Department of Children and Youth, and I will be financially responsible for any outstanding balances in these invoices.

Signature of Adoptive Parent	Date	Signature of Adoptive Parent	Date

RIGHT TO A STATE HEARING: You have a right to a state hearing before the agency 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 the JFS 04059 "Explanation of State Hearing Procedures." 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.

INSTRUCTIONS FOR COMPLETING DCY 01050, APPLICATION FOR POST ADOPTION SPECIAL SERVICES SUBSIDY

****Note: A separate application must be completed for each child. ****

SECTION I: ***Agency Information***

OhioKAN Navigator: Enter the name of the assigned Navigator. (For Agency Use)
OhioKAN Region: Enter the name of the OhioKAN region. (For Agency Use)
Date of Application: Enter the month, day and year in which this application was completed and submitted to OhioKAN

SECTION II: ***Family Information***

Name of Adoptive Parent(s): Enter the first and last name(s) of the adoptive parent(s).
Adoptive Family Address and Telephone Number: Enter the adoptive family's current address (including city, state and zip code) and telephone number.
Number of Children in Home: Enter the number of adopted, biological or other (i.e. kinship/foster care) children that reside in the home.
Annual Family Income: Enter the amount of the annual family income as reported on the most current IRS tax form (i.e. 1040, 1040 EZ, etc.).

SECTION III: ***Child Information***

Name of Adoptive Child: Enter the first and last name of the adoptive child.
Date of Birth: Enter the adoptive child's date of birth.
Gender: Enter the gender of the adoptive child.
Date Adoption Finalized: Enter the month, day and year in which the child's adoption was finalized.
Type of Adoption: Check the box that applies to the type of adoption.
Briefly Describe the Treatment Needs of the Child: Briefly describe what type of treatment is being sought for the child. Per Ohio Administrative Code (OAC) 5101:2-44-13.1, in order to be eligible for PASSS funds all of the following must be met: The child has physical or developmental disability or mental or emotional condition that either existed before the adoption petition was filed or developed after the adoption petition was filed and can be directly attributed to factors in the child's preadoption background or medical history, or biological family's background or medical history. (If more space is needed, an additional sheet may be attached).

SECTION IV: ***Services Requested***

Therapeutic Techniques Requested As part of the application process, a DCY 01052 "Credentials for Providers of PASSS Funded Therapeutic Services and Memorandum of Understanding" must be completed and submitted at the time of application. If the individual providing therapy is not a licensed provider, then PASSS funds shall not be approved.

Type of Therapy: Identify the type of therapy that is being requested for the child (psychiatric, psychological or substance abuse counseling or other).
Name of Provider: List the name of the individual that will be providing therapy to the child.
Licensing Board: List the name of the Licensing Board under which the provider is authorized to practice.
Cost of Service: Enter the cost of the service(s) requested as accurately as possible. *(Note: Educational costs are not to be included).*

Other Service(s) Requested Check the box that applies to the type of service(s) requested for the child. If requesting medical and/or mental health respite, these costs may not exceed $2,400, respectively, per child per state fiscal year (SFY).

Additional Respite: DCY may elect, on a case-by-case basis, to approve an additional $2,400 for mental health and/or $2,400 for medical respite under special circumstances as outlined in Ohio Administration Code 5101:2-44-13.1.
Cost of Service: Enter the cost of the service(s) requested as accurately as possible.

Out of Home Care Requested: Complete this section if the service requested is for residential treatment, in-patient hospitalization or treatment foster care. Approved services for any type of residential treatment facility or treatment foster care must be provided by a residential facility or foster care home that is licensed by the Ohio department of children and youth (DCY) or the Ohio department of mental health and addiction services (ODMHAS) or a comparable agency which is recognized by a state or a similar licensing body.

Residential Treatment: List the name of the residential treatment facility and the name of the agency in which the facility is licensed by. *(Note: Educational costs are not to be included).*
In-patient Hospitalization: List the name of the facility in which the child will receive in-patient services.
Treatment Foster Care: List the name of the agency in which the facility providing treatment foster care is licensed under.
Cost of Service: Enter the cost of the service(s) requested as accurately as possible.
Total: Enter the total costs of all services requested. *(Note: The total costs of all services requested are not to exceed $10,000 per child per SFY. If a DCY 01051, Application for Additional Post Adoption Special Services (PASSS) Funding, has been completed and approved, the total costs of all services requested are not to exceed $15,000 per child per SFY).*

SECTION V: *Resources*

Resources: Identify **all** the community resources that have been contacted (and the dates of those contacts) to provide assistance in addressing the child's physical or developmental handicap, or mental or emotional condition. If funding has been received from a resource not listed, please identify the resource in the section marked "other." Enter the month, day and year in which the resource was contacted, if applicable. Indicate the total amount of funding received, if applicable, from each resource that has been contacted.
Total Received: Enter the total amount of funding received from all the resources listed, if applicable.

SECTION VI: *Affirmation*

Documentation: A copy of **all** the documentation outlined in this section must be submitted along with the completed DCY 01050.
Adoptive Parent(s) Signature: By signing this application, you confirm that the information given in this application is accurate and you acknowledge that you are aware that you will be required to provide verification of your financial situation. (In accordance with section 2921.13 of the Ohio Revised Code, it is a misdemeanor of the first degree to knowingly falsify statements when the statement is made to secure benefits administered by a governmental agency or paid out of a public treasury).
Right to a State Hearing: This section informs you of your right to request a state hearing if you do not agree with the decision made by the agency.