COLORADO DEPARTMENT OF HUMAN SERVICES

_____County Department of _____ Services

TITLE IV-E ADOPTION ASSISTANCE AGREEMENT

_____
Agency Address and zip code

This agreement has been entered into, by, and, between the _____ County Department of _____ Services, hereafter called the "Department" and _____ , hereafter called the
(Name of Adoptive Parent(s))
"Adoptive Parent(s) of _____ DOB: _____
(Name of Adopted Child)

PROVISIONS OF AGREEMENT

This agreement for adoption assistance, which is signed prior to the effective date and finalization, is entered into by and between the "Department" and adoptive parent(s) for the purposes of facilitating the legal adoption of the above named child. The adoptive parent(s) verify that he/she/they will be unable to adopt said child without financial and/or medical assistance.

The adoptive parent(s) agree that he/she/they intend to adopt the child and agree to the terms and provision contained in this document. The Department will partially assist in expenses related to supporting the adoptive placement.

Additional assistance is not provided to cover inpatient psychiatric services, day treatment, and any type of out-of-home placement in any type of facility or educational services such as private schooling or tutoring.

This document is the initial adoption assistance agreement or an amendment to the initial agreement. The adoptive parent(s) agree that he/she/they intend to adopt the child named above and have signed this document prior to finalization of the adoption for the purposes of receiving adoption assistance payments and/or services for the adopted child under Titles XIX and XX of the Social Security Act from the time of adoptive placement.

☐ Initial Adoption Assistance Agreement
☐ Amendment to the Initial Adoption Assistance Agreement

I. ASSISTANCE

A. NON-RECURRING ADOPTION EXPENSES

The Department agrees to reimburse the adoptive parent(s) for expenses that are reasonable and necessary for the adoption to occur, subject to a maximum of $800. The expenses must:

1) directly relate to the legal adoption; and,
2) not be in violation of state or federal law; and,
3) not have been reimbursed from other sources of funds

Reimbursement may only be requested after adoption finalization or when an adoption disrupts prior to finalization. The request for reimbursement must be submitted no later than one (1) year after the date of adoption finalization or adoption disruption.

☐ Legal Fees $_____
☐ Adoption Fees $_____
☐ Other Expenses as specified $_____

B. MONTHLY ADOPTION ASSISTANCE

The amount of the monthly adoption assistance is based on the needs of the adopted child **and** the circumstances of the adoptive parent(s) and has been determined by mutual agreement between the adoptive parent(s) and the Department. The amount of adoption assistance shall not exceed the foster care maintenance minus the respite care payment for the adopted child, if he/she was in a foster home in the state of Colorado. Adjustments in the monthly adoption assistance amount may be made, **only**, with the concurrence of the adoptive parent(s) based on the needs of the child that were identified at the time the original adoption assistance agreement was signed by the adoptive parent(s), or changes are made in the maximum allowable monthly adoption assistance. The county department shall not add additional needs for an adoption assistance payment after the adoption decree has been issued. Documentation of changes in the adopted child's needs or family circumstances may be required. If it is determined by the Department that an overpayment has been made to the adoptive parent(s), the Department shall have authority to collect the overpayment through a mutual agreement with the adoptive parent(s). If this results in an unsuccessful collection, the Department shall have authority to pursue other collection efforts.

MAINTENANCE: (Adoption assistance payment amount must not exceed the foster care rate minus the respite payment.)

DAILY RATE: (Select one)

☐ Medicaid Only * $_____
☐ Long Term: (Ongoing) $_____
☐ Time Limited: (Identify time limit)
Approximate date of Termination of Agreement _____ $_____
Reason for time limitation: _____

*"Medicaid only" means no adoption assistance payment is provided at this time; however, due to the special needs described in the Application for Adoption Assistance, there exists the potential need for services. If this is a Medicaid only adoption assistance agreement, it will be reviewed as the child ages or the family's circumstances change. **(Type "0" on the line)**

C. STATE FUNDED ADOPTION ASSISTANCE PROGRAM

Adoption Case Services*
☐One Time:
(1) Transportation (purpose) _____ $_____
(2) Other (specify) _____ $_____
☐Ongoing:
(1) Transportation (purpose) _____ $_____
(2) Other (specify) _____ $_____
(3) Medical Assistance Benefits (if non-Medicaid) Annual Limit $_____

*The family must contact their adoption assistance worker to receive permission **PRIOR** to commencing the services to be paid by case services dollars.

D. MEDICAL CARE

Medical and dental services will be provided through the Medicaid Program (Title XIX of the Social Security Act). If the family moves to a state that is not reciprocal with the Medicaid program, the county providing the adoption assistance is financially responsible and shall arrange with the family for medical coverage for the child. Psychiatric and other counseling services **must be pre-authorized**, if not using Medicaid. If a needed service identified in the Agreement is not available in the new state of residence, the county making the original adoption assistance agreement remains financially responsible for providing the needed service.

E. SOCIAL SERVICES

Social Services will be provided through the Social Services Block Grant Program Title XX. The Adoption Assistance payment, Title XIX Medical Services and Title XX Social Services are available regardless of the state of residence. Families moving out-of state will be provided with a contact in the new state using the Interstate Compact on Adoption and Medical Assistance Program (ICAMA). Title XIX Medical Services and Title XX Social Services vary from state to state and are available to the child in accordance with the procedures of the state in which the child resides.

F. OTHER

(1) If the family receives SSI payments for this child, it is the adoptive parent(s)' responsibility to inform the Social Security Administration if the child is also receiving adoption assistance payments.

(2) ADOPTION ASSISTANCE PAYMENTS DO NOT COVER INPATIENT PSYCHIATRIC SERVICES, DAY TREATMENT, ANY TYPE OF OUT-OF-HOME PLACEMENT IN ANY TYPE OF FACILITY, OR, EDUCATIONAL SERVICES.

(3) ALL ADOPTION ASSISTANCE AGREEMENTS ARE REVIEWED EVERY THREE YEARS.

(4) Interstate Compact on Adoption Medical Assistance (ICAMA)
If the family moves out-of-state after the finalization of the adoption, the family must contact their county adoption worker to access medical assistance services in the new state. The county should be contacted 60 days prior to moving out-of-state.

G. EDUCATION REQUIREMENT

AS SOON AS THE CHILD HAS REACHED THE AGE OF COMPULSORY SCHOOL ATTENDANCE, ACCORDING TO COLORADO LAW, THE FAMILY MUST PROVIDE DOCUMENTATION THAT HE/SHE IS:

- ENROLLED IN AN INSTITUTION THAT PROVIDES ELEMENTARY OR SECONDARY EDUCATION, AS DETERMINED UNDER THE LAW OF THE STATE OR OTHER JURISDICTION IN WHICH THE INSTITUTION IS LOCATED; OR,
- INSTRUCTED IN ELEMENTARY OR SECONDARY EDUCATION AT HOME IN ACCORDANCE WITH A HOME SCHOOL LAW OF THE STATE OR OTHER JURISDICTION IN WHICH THE HOME IS LOCATED; OR,
- IN AN INDEPENDENT STUDY ELEMENTARY OR SECONDARY EDUCATION PROGRAM IN ACCORDANCE WITH THE LAW OF THE STATE OR OTHER JURISDICTION IN WHICH THE PROGRAM IS LOCATED, WHICH IS ADMINISTERED BY THE LOCAL SCHOOL OR SCHOOL DISTRICT; OR,
- INCAPABLE OF ATTENDING SCHOOL ON A FULL-TIME BASIS DUE TO THE MEDICAL CONDITION OF THE CHILD, WHICH INCAPABILITY IS SUPPORTED BY REGULARLY UPDATED INFORMATION IN THE CASE PLAN OF THE CHILD.
- THIS DOCUMENTATION MUST BE PROVIDED EVERY THREE (3) YEARS WHEN THE ADOPTION ASSISTANCE AGREEMENT IS REVIEWED.

☐ **Education documentation has been received.**
☐ **Education documentation is not required at this time.**

II. NOTIFICATION OF CHANGE

The adoptive parent(s) will immediately notify the Department, in writing, of any of the following events:

- ◊ change of address
- ◊ child's death, marriage, entry into the military service
- ◊ if they are no longer legally responsible for the support of the child
- ◊ if the child is removed from the home and placed into out-of-home care
- ◊ they are no longer providing any support to the child

III. AMENDMENT

This Agreement may be amended or cancelled at any time by mutual agreement of the Department and the adoptive parent(s), in writing as provided in Department rules and no oral modifications made by any employee or agent of the Department or any party to this agreement shall have any effect.

IV. REVIEW

This Agreement will be reviewed **every three years** by the adoptive parent(s) and the Department.

V. ASSESSMENT OF PARENTAL FEES FOR PLACEMENT OUT OF THE HOME

For children receiving Title IV-E adoption assistance:

- ◊ If the adoptive parents are receiving Title IV-E adoption assistance and the child is under the custody of the Department and placed in out-of-home for a duration of over thirty (30) calendar days, the Department and the family have two options:
- o To assess a placement fee from the family not to exceed the amount of the adoption assistance payment they are receiving under their adoption assistance agreement.
- o To execute an amended agreement, which would reduce the adoption assistance payment to $0 and place it on Medicaid-only status until such time that the child returns to the custody of the parent(s).
- ◊ The parental fee will **not** be discontinued because the child returns to the home of the adoptive parents for holidays or visits while the child is under the custody of the Department.
- ◊ During the time the adoption assistance payment is in Medicaid-only status, the parent(s) will not be assessed a parental share fee for the child's out-of- home placement costs.

VI. TERMINATION

Termination of the Adoption Assistance Agreement will occur in any of the following circumstances upon fifteen (15) days written notice to the adoptive parent(s), by certified mail or other method of service.

Termination shall be based upon verified information.

(1) The child has attained the age of 18, or age twenty-one (21) if the county determines that the child has a mental or physical disability, which would warrant continuation of assistance; or,
(2) The adoptive parent(s) is (are) no longer legally responsible for the support of the child; or
(3) The adoptive parent(s) is (are) no longer providing any support to the child; or
(4) Upon the child's death; or
(5) Upon the death of the parent(s) of the child (one parent - in a single parent household and both in a two-parent family); or
(6) Upon the adoptive parent(s)' written request.

VII. DURATION (to be completed by county department staff)

Unless termination occurs as a result of one or more of the conditions set forth in Section VI "Termination", this Agreement will expire:

☐ On the child's 18th birthday _____
(date child turns 18)

OR

☐ On the child's 21st birthday _____
(date child turns 21)

(When the child has been diagnosed as MR-Mentally Retarded; PH-Physically Handicapped)

OR

☐A time-limited duration expiration date will be:_____

VIII. APPEAL

This Agreement shall remain in effect in the event the child and adoptive parent(s) reside in, or move to, another county, state or country.

Adoptive parent(s) may appeal the agency's decision to reduce or terminate the adoption assistance. Such appeal will be in accordance with Rules and Regulations of the Department's appeal process. The Department will advise the parent(s) in writing, of their right to appeal. Information can be obtained from your local Department of Human/Social Services office.

If after preliminary talks with your county department you feel the county department is wrong, you should write a letter to the:

Colorado Department of Personnel and Administration
Office of Administrative Courts
633-17th Street, Suite 1300
Denver, Colorado 80202-3613
Phone: 303-866-2000
Fax: 303-866-5909

Be sure your letter includes the statement, "I want to appeal" and why. If you need help in writing your letter to the State Department for appeal, you can ask anyone you desire to help you, or talk to a legal-aid office, or ask your worker at the county department to help you. You must send your letter of appeal no later than fifteen (15) days after the county department has given you the decision with which you disagree.

If you believe you have been discriminated against because of race, color, sex, age, religion, political beliefs, national origin, or handicap, you have the right to file a complaint with:

(1) Colorado Department of Human Services
1575 Sherman Street
Denver, CO 80203

(2) Office of Civil Rights
Federal Office Building – Region VIII
1961 Stout St
Denver, CO 80294-3538

IX. ACKNOWLEDGEMENT

In completing and signing this agreement, I (we) certify that the information supplied herein is true, accurate, and complete to the best of my (our) knowledge. In addition, I (we) am (are) aware that if I (we) make a willfully false statement or representation, or use other fraudulent methods to obtain assistance to which I (we) am (are) not entitled, or greater than that, to which I (we) am (are) entitled, I (we) can be found guilty of a felony or misdemeanor under appropriate state or federal law.

I (WE) HAVE BEEN INFORMED AND UNDERSTAND THAT I (WE) AM (ARE) ELIGIBLE TO CLAIM THE ADOPTION TAX CREDIT EVEN IF I (WE) HAVE NOT INCURRED ANY ADOPTION EXPENSES. I (WE) UNDERSTAND THAT I (WE) NEED TO SPEAK TO MY (OUR) TAX PREPARER FOR FURTHER INFORMATION.

X. SIGNATURE AND DATES ARE REQUIRED BY ALL PARTIES

This agreement **must be signed and dated** by all parties prior to the effective date of this Agreement and before the adoption is finalized.

The adoptive parent(s) confirm that he/she/they has/have read and understand(s) this agreement.

IN TESTIMONY WHEREOF, THE PARTIES HERETO HAVE EXECUTED THE WITHIN AND FOREGOING INSTRUMENT, TO BE EFFECTIVE AS OF _____. (IF THE EFFECTIVE DATE IS TO BE AT ADOPTION FINALIZATION, A COPY OF THE FINAL DECREE MUST BE ATTACHED TO THIS FORM.)

_____ _____
SIGNATURE of Adoptive Parent Date signed

_____
(Print your full name)

_____ _____
SIGNATURE of Adoptive Parent Date signed

_____
(Print your full name)

_____ _____
SIGNATURE of Caseworker Date signed

_____
(Print your full name)

_____ _____
SIGNATURE of Supervisor Date signed

_____
(Print your full name and title)

_____ _____
SIGNATURE of County Director or Designee Date signed

_____
(Print your full name and title)

_____
Name of Agency