

County:
CCYA Case #:

CY-61 A: DETERMINATION OF ELIGIBILITY FOR ADOPTION ASSISTANCE

I. IDENTIFYING INFORMATION (PLEASE PRINT)

1a. Child's Birth Name (Last, First, MI):	2. DOB:	3. SSN:	4. Pre-Adoption MCI #:
1b. Child's Adoptive Name (Last, First, MI):			
5. Adoptive Parent(s) Name, Address & Phone Number:			
6. Was the child previously receiving federal or state SPLC payments? If yes, note whether federal or state: _____	<input type="checkbox"/> YES <input type="checkbox"/> NO	If yes, when determining whether the child meets AA eligibility criteria listed on this form, the placement of the child with the custodian and any federal state payments made on behalf of the child shall be considered never to have been made.	
6a. Date the federal or state SPLC was dissolved: ____ / ____ / ____			

II. ADOPTION ASSISTANCE ELIGIBILITY

Part A. ELIGIBILITY FOR TITLE IV-E NON-RECURRING EXPENSES

A1. Is the child under the age of 21 and in the placement care and responsibility of CCYA or a private agency licensed by PA DHS? <i>In independent private adoptions, the following children may be eligible for AA (Select yes for the following exceptions):</i> • A federal or state SPLC child meeting AA criteria; • A child received Title IV-E AA in a previous adoption; or • A child determined eligible for SSI by the SSA.	<input type="checkbox"/> YES <input type="checkbox"/> NO	If yes, continue to question A2. If no, child is ineligible. Skip to Section III, question 5.
A2. Is the child a citizen or qualified non-citizen?	<input type="checkbox"/> YES <input type="checkbox"/> NO	If yes, continue to question A3. If no, child is ineligible. Skip to Section III, question 5.
A3. Does the child meet the special needs requirements? (To meet this requirement, yes must be checked for 3a, 3b, & 3c.)	<input type="checkbox"/> YES <input type="checkbox"/> NO	If yes, continue to question A4. If no, child is ineligible. Skip to Section III, question 5.
3a. Child is legally free for adoption?	<input type="checkbox"/> YES <input type="checkbox"/> NO	If 3b. is yes, check all that apply:
3b. Child has a special needs characteristic? (If yes, at least one box must be checked in 3rd column.)	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> Physical, mental/emotional condition or handicap <input type="checkbox"/> Pathogenic exposure
3c. Reasonable efforts were made to place the child without AA? (Check "Yes" when this requirement was unnecessary due to the child's significant emotional ties with the prospective adoptive parent(s) or adoption by relative.)	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> Member of sibling group placed together <input type="checkbox"/> Genetic condition <input type="checkbox"/> Five years of age or older <input type="checkbox"/> Member of minority group
A4. The adoptive parent(s) and household members 18 years of age and older have not been convicted of one or more of the offenses under Title 18 (relating to crimes and offenses) or an equivalent crime under federal law or the law of another state or a felony conviction within the past 5 years for physical assault, battery, or a drug-related offense and have an approved home study?	<input type="checkbox"/> YES <input type="checkbox"/> NO	If yes, child is eligible, proceed to A5. If no, child is ineligible. Skip to Section III, question 5.

A5. ☐ All criteria met in Part A. Child is eligible for Title IV-E Non-Recurring Expenses. Proceed to Part B.

Part B. ELIGIBILITY FOR TITLE IV-E MONTHLY SUBSIDY AND MEDICAID

A non-applicable child must meet the special needs requirements (Part A) and one of the following: 1, 2, 3, or 4 below.

B1. Was the child eligible for AFDC at removal?	<input type="checkbox"/> YES <input type="checkbox"/> NO	If yes, child eligible for Title IV-E monthly subsidy as a non-applicable child. Skip to B6. If no, continue to B2.
1a. Was the child removed from the home of a specified relative?	<input type="checkbox"/> YES <input type="checkbox"/> NO	To meet AFDC criteria at removal, yes must be checked for 1a, 1b, and 1c and at least one yes must be checked for 1d or 1e.
1b. Did the child reside in the home of the specified relative within six months prior to the eligibility month?	<input type="checkbox"/> YES <input type="checkbox"/> NO	There does not have to be a judicial determination that reasonable efforts were made to prevent the child's removal for the child to be eligible for Title IV-E AA.
1c. Did the child meet the financial need and deprivation requirements in the eligibility month?	<input type="checkbox"/> YES <input type="checkbox"/> NO	
1d. Does the initial agency care/responsibility court order authorizing removal contain the CTW/BI language?	<input type="checkbox"/> YES <input type="checkbox"/> NO	
1e. Did the specified relative sign a VPA and at least one Title IV-E foster care payment was made on behalf of the child?	<input type="checkbox"/> YES <input type="checkbox"/> NO	
B2. Is the child eligible for SSI (medical, disability, and needs-based) prior to adoption as determined by SSA?	<input type="checkbox"/> YES <input type="checkbox"/> NO	If yes, child eligible for Title IV-E monthly subsidy as a non-applicable child. Skip to B6. If no, continue to B3.
B3. Is the child's minor parent Title IV-E eligible in foster care pursuant to a CTW/BI finding or VPA?	<input type="checkbox"/> YES <input type="checkbox"/> NO	If yes, child eligible for Title IV-E monthly subsidy as a non-applicable child. Skip to B6. If no, continue to B4.
B4. Child was eligible for Title IV-E as a non-applicable child in a previous adoption? (If yes, the child is to be treated as if the adoption did not occur; the child's circumstances are the same as those prior to the previous adoption. The child would need to meet only the special needs requirements [Part A] in the subsequent adoption.)	<input type="checkbox"/> YES <input type="checkbox"/> NO	If yes, child eligible for Title IV-E monthly subsidy as a non-applicable child. Skip to B6. If no, assess if the child meets the applicable child eligibility requirements, continue to B5.

B5. An applicable child must meet the special needs requirements (Part A) and 5a or 5b or 5c and at least one of 5d through 5g effective 10/1/09.		<input type="checkbox"/> YES <input type="checkbox"/> NO	If yes, continue to B6. If no, skip to Part C.																								
5a. The child attained the applicable age any time before the end of the federal fiscal year in which the adoption agreement was entered into?		<input type="checkbox"/> YES <input type="checkbox"/> NO																									
<table><tr><th>FEDERAL FISCAL YEAR</th><th>APPLICABLE AGE OF CHILD</th></tr><tr><td>2010 (10/1/09 – 9/30/10)</td><td>16</td></tr><tr><td>2011 (10/1/10 – 9/30/11)</td><td>14</td></tr><tr><td>2012 (10/1/11 – 9/30/12)</td><td>12</td></tr><tr><td>2013 (10/1/12 – 9/30/13)</td><td>10</td></tr><tr><td>2014 (10/1/13 – 9/30/14)</td><td>8</td></tr><tr><td>2015 (10/1/14 – 9/30/15)</td><td>6</td></tr><tr><td>2016 (10/1/15 – 9/30/16)</td><td>4</td></tr><tr><td>2017 (10/1/16 – 9/30/17)</td><td>2</td></tr><tr><td>2018 (10/1/17-12/31/17)</td><td>Any age</td></tr><tr><td>2018-2024 (1/1/18-6/30/24)</td><td>2 AFDC Delink delay due to Family First</td></tr><tr><td>2024 (7/1/24 and thereafter)</td><td>Any age</td></tr></table>		FEDERAL FISCAL YEAR	APPLICABLE AGE OF CHILD	2010 (10/1/09 – 9/30/10)	16	2011 (10/1/10 – 9/30/11)	14	2012 (10/1/11 – 9/30/12)	12	2013 (10/1/12 – 9/30/13)	10	2014 (10/1/13 – 9/30/14)	8	2015 (10/1/14 – 9/30/15)	6	2016 (10/1/15 – 9/30/16)	4	2017 (10/1/16 – 9/30/17)	2	2018 (10/1/17-12/31/17)	Any age	2018-2024 (1/1/18-6/30/24)	2 AFDC Delink delay due to Family First	2024 (7/1/24 and thereafter)	Any age		<i>An applicable child removed by voluntary removals does not require Title IV-E payment under a VPA nor does there have to be CTW language.</i>
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2010 (10/1/09 – 9/30/10)	16																										
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2024 (7/1/24 and thereafter)	Any age																										
5b. Has the child been in foster care under the placement care and responsibility of a CCYA for 60 consecutive months?		<input type="checkbox"/> YES <input type="checkbox"/> NO																									
5c. Is the child a sibling of an applicable child by virtue of age as described by 5a. or time in foster care as described by 5b. and placed into the same adoption arrangement as said sibling?		<input type="checkbox"/> YES <input type="checkbox"/> NO																									
5d. Was the child removed from the home as a result of a CTW/BI finding or a VPA or a voluntary relinquishment at the initiation of the adoption proceedings?		<input type="checkbox"/> YES <input type="checkbox"/> NO																									
5e. Is the child's minor parent in foster care pursuant to a CTW/BI finding or VPA?		<input type="checkbox"/> YES <input type="checkbox"/> NO																									
5f. Did the child meet all medical and disability requirements (not the needs-based requirement) for SSI prior to the finalization of the adoption as determined by SSA?		<input type="checkbox"/> YES <input type="checkbox"/> NO																									
5g. Child was eligible for Title IV-E AA as an applicable child in a previous adoption?		<input type="checkbox"/> YES <input type="checkbox"/> NO																									
B6. <input type="checkbox"/> Child is eligible for Title IV-E monthly subsidy and Medicaid. Proceed to Section III, Question 2.																											
Part C. ELIGIBILITY FOR STATE MONTHLY SUBSIDY AND MA																											
C1. Is the child in the legal custody of the CCYA or a licensed private agency approved by DHS?		<input type="checkbox"/> YES <input type="checkbox"/> NO	If yes, continue to question C2. If no, child is ineligible. Skip to Section III, question 1.																								
C2. Did the child reside in foster care for at least six months?		<input type="checkbox"/> YES <input type="checkbox"/> NO	If yes, continue to question C3. If no, child is ineligible. Skip to Section III, question 1.																								
C3. <input type="checkbox"/> Child is eligible for state monthly subsidy and MA. Proceed to Section III, Question 3 for an in-state adoption or proceed to Part D for an out-of-state adoption of a PA child.																											
Part D. PA CHILD PLACED FOR ADOPTION OUT-OF-STATE																											
D1. According to the child's record, the child cannot be placed for adoption out-of-state without MA due to special needs or medical or rehabilitative care?		<input type="checkbox"/> YES <input type="checkbox"/> NO	If yes, continue to question D2. If no, skip to Section III, question 4.																								
D2. <input type="checkbox"/> Documentation requirement fulfilled. Proceed to Section III, Question 3.																											
III. CCYA DETERMINATION OF ELIGIBILITY FOR ADOPTION ASSISTANCE																											
1. <input type="checkbox"/> Child is eligible for Title IV-E non-recurring expenses only.																											
2. <input type="checkbox"/> Child is eligible for Title IV-E AA, IV-E Medicaid and IV-E non-recurring expenses.		2a. <input type="checkbox"/> Child is eligible due to the applicable child criteria ONLY.																									
3. <input type="checkbox"/> Child is eligible for state AA, state MA, and Title IV-E non-recurring expenses or fulfills documentation requirement for state MA outside of PA.																											
4. <input type="checkbox"/> Child is eligible for state AA, state MA, and Title IV-E non-recurring expenses. Child MAY NOT be eligible for state MA outside of PA.																											
5. <input type="checkbox"/> Child is ineligible for Title IV-E non-recurring expenses, Title IV-E AA, state AA, and medical coverage.																											
6. Effective date of the adoption assistance agreement:		7. Child's age when agreement was executed:	8. Adoption finalization date:																								
NAME: (Please Print)		SIGNATURE:	DATE:																								
CCYA forwards to CAO. If adoptive parents request the child's name to change on Medicaid/MA Card, check here and attach adoption decree. <input type="checkbox"/>																											
IV. CAO CERTIFICATION FOR MEDICAID OR MA																											
I certify that the adoptive child is eligible for Medicaid OR MA under program status code: _____ The child has been assigned a new MCI #: _____																											
<input type="checkbox"/> I have issued a new Access card for the child directly to the adoptive parent(s) at the above address.																											
<input type="checkbox"/> MCO correction form is completed for those adoptive parent(s) selecting to retain child's current MCO coverage.																											
NAME: (Please Print)		SIGNATURE:	DATE:																								