

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 (<i>first and last</i>)		Name of Adoptive Mother (<i>first and last</i>)	
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
Social Security Number		Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Date Adoption Finalized
Type of Adoption <input type="checkbox"/> Attorney <input type="checkbox"/> International <input type="checkbox"/> Private <input type="checkbox"/> Public		Was the child adopted by a relative? <input type="checkbox"/> Yes <input type="checkbox"/> No	
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			
<i>These therapies address behavioral, emotional or other mental health issues (Check all that apply)</i>			
Type of Therapy	Name of Provider	Licensing Board	Cost of Service(s)
<input type="checkbox"/> Psychiatric Counseling			\$
<input type="checkbox"/> Psychological Counseling			\$
<input type="checkbox"/> Substance Abuse Counseling			\$
<input type="checkbox"/> Other (<i>Specify</i>)			\$
<input type="checkbox"/> Other (<i>Specify</i>)			\$
OTHER SERVICES REQUESTED			\$
<input type="checkbox"/> Occupational Therapy	<input type="checkbox"/> Physical Therapy	<input type="checkbox"/> Speech Therapy	\$
Respite (<i>Check all that apply</i>)	<input type="checkbox"/> Medical (\$2,400 MAXIMUM)	<input type="checkbox"/> Mental Health (\$2,400 MAXIMUM)	\$
Additional Respite (<i>Check all that apply</i>)	<input type="checkbox"/> Medical (\$2,400 MAXIMUM)	<input type="checkbox"/> Mental Health (\$2,400 MAXIMUM)	\$
<input type="checkbox"/> Medical Equipment	<input type="checkbox"/> Surgery		\$
OUT OF HOME CARE REQUESTED			
Type of Out of Home Care	Name of Treatment Facility	Licensed By	Cost of Service(s)
<input type="checkbox"/> Residential Treatment (<i>EXCLUDING EDUCATIONAL COSTS</i>)			\$
<input type="checkbox"/> In-patient Hospitalization			\$
<input type="checkbox"/> 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).

<input type="checkbox"/> Alcohol and Drug Addiction Board	<input type="checkbox"/> Yes <input type="checkbox"/> No	DATE	\$
<input type="checkbox"/> Alcohol, Drug Addiction and Mental Health (ADAMH)	<input type="checkbox"/> Yes <input type="checkbox"/> No	DATE	\$
<input type="checkbox"/> Family and Children First Council	<input type="checkbox"/> Yes <input type="checkbox"/> No	DATE	\$
<input type="checkbox"/> Medicaid	<input type="checkbox"/> Yes <input type="checkbox"/> No	DATE	\$
<input type="checkbox"/> MR/DD Family Resource Program	<input type="checkbox"/> Yes <input type="checkbox"/> No	DATE	\$
<input type="checkbox"/> Prevention, Retention, Contingency Fund	<input type="checkbox"/> Yes <input type="checkbox"/> No	DATE	\$
<input type="checkbox"/> Private/Family Insurance	<input type="checkbox"/> Yes <input type="checkbox"/> No	DATE	\$
<input type="checkbox"/> Public School District	<input type="checkbox"/> Yes <input type="checkbox"/> No	DATE	\$
<input type="checkbox"/> State Adoption Subsidy	<input type="checkbox"/> Yes <input type="checkbox"/> No	DATE	\$
<input type="checkbox"/> Title IV-E Adoption Assistance	<input type="checkbox"/> Yes <input type="checkbox"/> No	DATE	\$
<input type="checkbox"/> Title XX Benefits	<input type="checkbox"/> Yes <input type="checkbox"/> No	DATE	\$
<input type="checkbox"/> Veteran's Benefits	<input type="checkbox"/> Yes <input type="checkbox"/> No	DATE	\$
<input type="checkbox"/> Other	<input type="checkbox"/> Yes <input type="checkbox"/> 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
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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.

Ohio Department of Job and Family Services
**CREDENTIALS FOR PROVIDERS OF PASSS FUNDED THERAPEUTIC SERVICES
 AND MEMORANDUM OF UNDERSTANDING**

Child's Name <i>(first and last)</i>	Date of Birth
Specify the therapy being provided to the child	
Professional Experience (please describe your professional experience with the therapy being provided to the child)	
Education and Training (please list all specific education and training relative to the therapy being provided to the child)	
Professional Credentials	
Name of Provider <i>(first and last)</i>	
Name of Practice/Office	
Street Address of Practice/Office	
City, State and Zip Code	(Area Code) Telephone Number
Ohio License #	Licensing Board
<p><i>My therapeutic interventions will comply with all treatment aspects contained in Ohio Administrative Code rules 5122-26-16 "Special treatment and safety measure," 5122-26-16.1 "Mechanical restraint and seclusion," 5122-26-16.2 "Physical restraint" and 5122-26-16.3 "Aversive behavioral interventions and plans." I proclaim competence to the therapeutic technique(s) specified and acknowledge that my practice is governed under laws and rules of the occupational regulatory board specified above.</i></p>	
Signature of Provider	Date