|  |  |  |  |
| --- | --- | --- | --- |
| **Foster Parent(s)** |  | **Date** |  |
| **Mailing Address** |  | **Day Phone Number** |  |
| **City, State, ZIP** |  | **Email Address** |  |

| Name of child: | | | | | | |
| --- | --- | --- | --- | --- | --- | --- |
| Can you adopt/become guardian of this child without financial assistance?  Yes  No | | | | | | | |
| What are the special needs of the child? (diagnosis, behavioral challenges, care needed that is more than for most children of the same age, medical needs) | | | | | | | |
| What services are they currently receiving or what do they need that is not yet in place (such as counseling, speech or occupational therapy, or other services to meet their special needs)? | | | | | | | |
| What are your out of pocket expenses for meeting the child’s ordinary and special needs? | | | | | **Approx. Monthly Cost** |
| 1. Child care for employment purposes | | | | | $ |
| 2. Extraordinary transportation required to meet special needs | | | | | $ |
| 3. Medically necessary therapy if no Medicaid/insurance resources are available. | | | | | $ |
| 4. Private insurance premiums/deductible for child | | | | | $ |
| 6. Other (please list): | | | | | $ |
| Other family circumstances which should be considered: | | | | | |
| OTHER RESOURCES AVAILABLE TO THE CHILD (if known) | | | | | |
|  |  |  |  |  | |
|  |  | Social Security Disability (Amount if known) |  | Medicaid Waiver | |
|  |  |  |  |  | |
|  |  | Private Insurance/Indian Health Services |  | Survivor or parent disability benefit | |
|  |  |  |  |  | |
| Of the out of pocket expenses above, what portion are you be able to provide? (7AAC 53.245 (d) 13) | | | | | |

Please bring this worksheet to your subsidy negotiation meeting, or mail or email it to your subsidy negotiator.