Department of Health & Human Services
DHHS
NEBRASKA

Nebraska Health and Human Services System
STATE SUBSIDIZED ADOPTION AGREEMENT FOR CHILDREN RECEIVING STATE SUBSIDIZED GUARDIANSHIP

Child's Name:_____

Birth Date: _____

Adoptive Parent(s) Name: _____

_____

Address:_____

City, State, Zip Code:_____

Telephone:_____

The following agreement has been entered into between the Nebraska Department of Health and Human Services and the adoptive parent(s).

A. General Provisions

1. The amount of the maintenance payment cannot be more than is currently paid under the subsidized guardianship agreement and cannot be more than would have been paid for the child if s/he would be in custody of the Department. If other maintenance payments (for example, SSI or SSA) are being received for the child, they will be deducted from the amount paid by the Department. The only exception to this deduction is a payment received for the child based on the adoptive parent's disability or retirement or death benefit.

2. This subsidy will be provided in keeping with state legislation and Department regulations.

3. This agreement may be changed or cancelled at any time by mutual agreement.

4. This agreement shall remain in effect regardless of the state of resident of the adoptive parent(s) and child.

5. Existence of subsidy does not diminish the adoptive parent(s)' legal status or responsibility, including financial, for the child.

6. If the child resides in Nebraska and is Medicaid eligible, medical services including mental health or substance abuse, will be available under subsidy only as provided by Nebraska's Medicaid program, using all applicable guidelines, rates and requirements.

7. If the child resides in Nebraska and is not Medicaid eligible, he/she will receive state funded medical. Medical care and treatment will be provided using all applicable Nebraska Medicaid rules, regulations, requirements and payment rates. The adoptive family must use other available resources, benefits, and programs, including but not limited to private insurance coverage before requesting payment from subsidy.

8. If the child resides outside the State of Nebraska and receives Medicaid coverage from the state of residence, Nebraska Medicaid coverage will end. Medicaid coverage will be provided under the guidelines, rates and services established by that state.

9. If the child resides outside the State of Nebraska and does not qualify for Medicaid in the state of residence, he/she will continue to receive Nebraska Medicaid. If the adoptive parent is unable to locate providers who are or will become Nebraska Medicaid providers, the Department will work with the adoptive parent(s) in locating and making arrangements for payment for medical care and treatment using Nebraska Medicaid guidelines, rates and services.

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B. Termination of the Agreement

This agreement shall terminate:

1. When the child becomes ineligible due to age or becomes emancipated;
2. If the child dies;
3. Upon the death of one parent in a single parent family or both in a two parent family;
4. At the request of the parent(s); or by mutual agreement that subsidy is no longer required;
5. If the parent(s) no longer are legally responsible for or no longer financially supporting the child; or
6. If change in state laws/regulations make a renegotiation necessary, and either party is unwilling to enter into a new agreement.

C. The Adoptive Parent(s) agrees to:

1. Notify the Department in writing within two weeks of changes which relate to continued need for subsidy or the child's eligibility or potential changes in coverage, such as approval for, or increase in, monetary benefits for the child (e.g., SSI); child's marriage, entry into military, move from the home, placement outside the home, full-time employment, death, or age of majority.
2. Notify the Department, in writing, within two weeks, of change in address.
3. Notify the Department, in writing, immediately if they are no longer legally responsible for the support of the child or are no longer supporting the child.
4. Utilize other available resources for medical/mental health treatment/care before requesting payment under subsidy, e.g., private insurance, other programs.
5. Make a self-determination of need prior to requesting payment for care, treatment, or services under subsidized adoption.

D. The Department agrees to:

1. Provide the following:
   a. ☐ Medicaid until the child's _____ birthday.
   b. ☐ State funded Medical Services (for children who do not qualify to receive Medicaid)
   c. ☐ Monthly maintenance payment of $_____, which is equal to or less than was paid in the subsidized guardianship. This payment will be made until _____.
   d. ☐ Respite Care payment of $_____ monthly, only if it was included in the subsidized guardianship. Payment for respite care will end at the child's 13th birthday unless the adoptive parent(s) provide documentation from a doctor or other qualified medical or mental health provider that states the child cannot be left unattended due to a danger to him/herself or others.
   e. ☐ Child Care in accordance with the Department's Child Care Subsidy Program. Payment will be made directly to the provider and will end at the child's 13th birthday unless the adoptive parent(s) provide documentation from a doctor or other qualified medical or mental health provider that states the child cannot be left unattended due to a danger to him/herself or others
   f. ☐ Other services that were provided in the subsidized guardianship agreement, which are:

2. Notify the adoptive parent(s) within 30 days in the event that state laws or Department regulations change, requiring a new agreement.

E. The adoptive parent(s) may appeal the Department's decision to reduce or terminate the subsidy, as covered in the agreement. Such appeal will be in accordance with rules and procedures of the Department's Fair Hearing and Appeal process.

F. This agreement must be signed by the adoptive parent(s) and a designated Department representative before the finalization of the adoption.

SIGNATURES

Print Name of Guardian

Signature of Guardian

Date

Print Name of Guardian

Signature of Guardian

Date

Approved

☐ Yes ☐ No

If no state section and the reasons:

Print Name of DHHS Staff

Signature of DHHS Staff

Date