Department of Health & Human Services
DHHS
NEBRASKA

Nebraska Health and Human Services System
DETERMINATION OF ELIGIBILITY AND APPLICATION FOR SUBSIDIZED ADOPTION FOR CHILDREN IN SUBSIDIZED GUARDIANSHIP

Child's Name:_____

Date of Birth: _____

Adoptive Parent(s) Names: _____

_____

Address:_____

City, State, Zip Code:_____

Telephone:_____

Child is a citizen or legal resident of the United States.

☐ Yes ☐ No

I/we is/are the current guardian(s) of the child _____, who was formerly a ward of the Department of Health and Human Services.

☐ Yes ☐ No

I/We guardian(s) currently have an active subsidized guardianship agreement with the Department of Health and Human Services. (The Subsidized Guardianship Agreement must be attached or submitted to the Department as part of this Determination)

I/we understand that the maximum benefits received under the subsidized adoption can be no greater than those currently received under the subsidized guardianship.

I/We apply for the following subsidized adoption:

Medicaid

☐ Yes ☐ No

State Funded Medical Coverage (available only if the child is not eligible for Medicaid)

☐ Yes ☐ No

Maintenance Payment

☐ Yes ☐ No Payment $_____

Respite Care

☐ Yes ☐ No Payment $_____

Child Care in accordance with the Child Care Subsidy Regulations

☐ Yes ☐ No

Other Services that are provided in the Subsidized Guardianship Agreement:

I/We understand that I/we have the right to Apply for Non-Recurring subsidy to reimburse us for the costs incurred in finalizing the adoption and that I/we must make separate application for that subsidy.

Submitted by Guardians:

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:

Approved, but different from what is requested by the guardian(s)
☐ Yes ☐ No

Change:

Print Name of DHHS Staff Authorized to Approve

Signature of DHHS Staff Authorized to Approve

Date