Connecticut Department of Children and Families
SUBSIDIZED GUARDIANSHIP APPROVAL CHECKLIST
DCF-2051G
10/20 (Rev.)

DCF SW LAST Name:	DCF SW FIRST Name:	DCF Office: Select DCF Office		
Child LAST Name	Child FIRST Name	Child's DOB:	Child's SS #:	Date:
Medical #:	State of Residence:	Is Child DDS Eligible?: ☐ Yes ☐ No	Does Child Receive Medicaid From Out-of-State? ☐ Yes ☐ No	

CHECK BELOW FOR TYPE OF SUBSIDY:

Please enter the Per Diem Rate, based upon the box checked on the left: _____

- ☐ Basic Financial and Medical
- ☐ Medical Only
- ☐ Medically Complex - packet must include DCF-2101 signed by RRG and treating physician within the previous six months. The child's doctor must check the box that child is certified as medically complex.
- ☐ Therapeutic/Professional - Packet must include letter stating per diem rate and need for continued rate and family's home study. Per diem rate set by therapeutic/professional foster care agency:
- ☐ Other - any guardianship subsidy rate higher than a basic rate or when a child is not in a TFC-approved home, must include Office Director's or Assistant Bureau Chief signed approval memo with per diem rate.
- ☐ Exceptional Expense Subsidy: _____
- ☐ IV-E: Is this child IV-E eligible? ☐ Yes ☐ No
- ☐ Related Siblings: Is this child related only to a sibling in the provider's home and not to the provider? ☐ Yes ☐ No

PACKET MUST BE SIGNED BY PROPOSED GUARDIAN AND DCF STAFF WHERE APPLICABLE AND INCLUDE:

- ☐ Copy of Birth Certificate
- ☐ Copy of Social Security Card
- ☐ DCF-2101, Medically Complex Certification form signed and checked as certified by child's physician (if applicable)
- ☐ DCF-2158, Assessment of Child and Family for Subsidized Guardianship
- ☐ DCF-2159, Application for Guardianship Subsidy (including approved Exceptional Expense Subsidy)
- ☐ DCF-418-I-G, Initial Agreement for a Guardianship Subsidy
- ☐ DCF-552-G,Title IV-E Guardianship Subsidy Application
- ☐ JD-JM-31, Order of Termination of Parental Rights
- ☐ JD-JM-58, Order of Temporary Custody
- ☐ JD-JM-65, Adjudicatory/Dispositional Orders
- ☐ MA-1 Medical Assistance Form
- ☐ REU emails from Revenue Enhancement regarding IV-E status and Social Security benefits status prior to Transfer of Guardianship

Date child was placed in foster Care:	Date child placed by DCF with Guardian:	*Note: In order to be eligible for a DCF financial or medical subsidy, the child must be currently in the care of the proposed guardian and have been in licensed or approved foster care for at least six months before the TOG may occur in SCJM.*

PROPOSED GUARDIAN INFORMATION:

LINK Provider #:	Parent #1 LAST Name:	Parent #1 FIRST Name:	Parent #2 LAST Name:	Parent #2 FIRST Name:

☐ Licensing worker has verified that all licensing and background checks are in the provider fine.

OUT-OF-STATE PROPOSED GUARDIAN INFORMATION:

Out-of-state guardians must have a current license or approval from the state in which they reside that is in effect on the date of the Transfer of Guardianship in SCJM.	License Date:	License Expiration Date:

Copies in Packet: (*Note: Some states may not provide copies of actual background checks but will send a letter to confirm that background checks were completed and that the family was approved or licensed)*

- ☐ Approved DCF-100-A
- ☐ Copy of proposed guardian's approved home study
- ☐ Copies of background checks for any person age 16 and over in proposed guardian's household.

Reviewed by (Name of DCF Social Work Supervisor):	Signature of DCF Social Work Supervisor:	Date:
Reviewed by (Name of Subsidy Permanency Specialist CSC):	Signature of Subsidy Permanency Specialist CSC:	Date:
Approved by (Name of Subsidy Unit Program Supervisor):	Signature of Subsidy Unit Program Supervisor:	Date:

Connecticut Department of Children and Families
CERTIFICATION OF A CHILD WITH COMPLEX MEDICAL NEEDS
DCF-2101
6/19 (Rev.)

SECTION I – TO BE COMPLETED BY DCF SOCIAL WORKER			
Placement Date:	☐ Initial Certification	☐ Six Month Review	☐ Annual Review
Child LAST Name:	Child FIRST Name:	DOB:	Gender: Select One or enter your own
DCF Office: Select DCF Office		Case ID #:	Person ID #:

SECTION II. TO BE COMPLETED BY THE CHILD'S PRIMARY HEALTH CARE PROVIDER.
Check the corresponding box that most closely describes the needs of the above named child at this time.

☐ 1. **Potential Condition-Related Risk** means a child who has a chronic health condition which is under good control but requires an educated caregiver. Chronic diseases in this classification include, but are not limited to; mild or moderate persistent asthma; cancer in remission until child is medically cleared by the medical provider; chronic infections such as Hepatitis C and latent TB which require monitoring but no treatment; well-identified allergies which require Epi-pen use; and a newborn with perinatal substance exposure requiring medication upon discharge;

☐ 2. **Medically at Risk** means a premature infant (born at less than 32 weeks gestation) or a child who has a chronic health condition which may periodically become life-threatening such as well-controlled insulin-dependent diabetes; a well-controlled seizure disorder requiring medication; and moderate-to-severe asthma that has not resulted in a pediatric intensive care (PICU) or acute hospitalization in the last six months; a chronic infection such as hepatitis C and latent tuberculosis, for which the child is receiving treatment. (Note: Conditions resulting in repeated hospitalizations should be classified as level 3)

☐ 3. **Intensive Medical Needs** means a child with a chronic condition that is not well-controlled and/or which requires daily or regular intensive medical follow-up or treatment, including severe forms of chronic disease such as poorly-controlled insulin-dependent diabetes; diabetes that requires the use of insulin pumps; a poorly controlled seizure disorder; hemophilia; immune disorder; and severe persistent asthma which requires intensive and ongoing medical follow-up or has required an acute hospitalization or PICU admission in last 6 months

☐ 4. **Technology Dependent or Medically Dependent**

Technology Dependent means a child who requires a mechanical device or special technological intervention to maintain or sustain life. Children in this classification require routine or periodic assistance from trained or licensed nursing personnel and the availability of professional skilled nursing personnel for assessment of the child's medical status. Examples of children who are technology-dependent are those who require substantial assistance with activities of daily living; those who are unable to ambulate independently due to cerebral palsy or developmental disabilities; and those who may be temporarily unable to ambulate independently due to an injury or surgery, but who are expected to remain in this status only temporarily.

OR

Medically Dependent means a child whose medical status require specially-trained personnel immediately available to attend to the child, for whom a skilled nursing assessment may be needed as frequently as every two hours, or for whom round-the-clock nursing care is required. Children who are medically-dependent may be able to live outside of a medical care facility, but are dependent upon a high level of care and assessment in order to sustain life, such as children with tracheostomies or on ventilators.

Medical Diagnoses:

PRIMARY HEALTH CARE PROVIDER'S CERTIFICATION OF COMPLEX MEDICAL NEEDS:

☐ I certify that this child requires the care checked above.

☐ I certify that this child currently requires NONE of the care listed above.

Health Care Provider's LAST Name:	Provider's FIRST Name:	Health Care Provider's Signature::	Date:

SECTION III – TO BE COMPLETED BY DEPARTMENT OF CHILDREN AND FAMILIES STAFF

RRG Nurse LAST Name:	RRG Nurse FIRST Name:	RRG Nurse Signature:	Date:
SW LAST Name:	SW FIRST Name:	SW Signature:	Date:
SWS LAST Name:	SWS FIRST Name:	SWS Signature:	Date:
PS LAST Name:	PS FIRST Name:	PS Signature:	Date:

DCF SOCIAL WORKER: File original in child's record; copy to RRG Nurse

Connecticut Department of Children and Families
ASSESSMENT OF CHILD AND FAMILY FOR GUARDIANSHIP
DCF-2158
10/19 (Rev.)

This assessment will be submitted for review by the Planning Team for final recommendation to transfer guardianship, and will be submitted as the Child and Family Assessment section of the Court Study for the transfer of guardianship.

Child LAST Name:	Child FIRST Name:	DOB:	Gender: Select One or enter your own
LAST Name of Caregiver/Guardian #1:	FIRST Name of Caregiver/Guardian #1:	LAST Name of Caregiver/Guardian #2:	FIRST Name of Caregiver/Guardian #2:

Address (No. and Street):	Apartment #:	City:	State:	Zip:
Date of Most Recent Foster Care License	Date of Child's Placement with Caregiver		Dates of Assessment Home Visits:	

Names of Members of Household	DOB	Relationship to Child	Dates Interviewed
		Please Select One	
		Please Select One	
		Please Select One	
		Please Select One	
		Please Select One	
		Please Select One	
		Please Select One	
		Please Select One	

HOME Living situation (describe living accommodations, sleeping arrangements, safety issues):

CHILD'S INFORMATION

Placement History:

Medical History (significant birth history, chronic medical conditions, allergies, medications, surgeries, etc.):

Educational information (school, grade, academic progress, special education needs):

Behavioral Health History (personality description, specific problem behaviors, any formal evaluations, therapeutic interventions):

Relationship with the birth parents (frequency of contact, attachment):

Relationship with siblings and reason child has been separated from siblings, if any:

Relationship with the proposed guardian(s) and other household members:

has developed a strong attachment to the proposed guardian.

Adjustment to the home and community:

Does the child wish to stay in this home? ☐ Yes ☐ No. Explain: (Note: discussion required with child age 14 or older)

Does the child go to the proposed guardian(s) for comfort and solace? ☐ Yes ☐ No. Explain:

If the child is non-verbal, describe the child's interaction with the proposed guardian(s) and other household members:

Steps taken to determine that it is not appropriate for the child to be returned home or adopted:

RELATIVE CAREGIVER(S) / PROPOSED GUARDIAN(S)

Degree of relatedness to the child (aunt, uncle, grandmother, stepparent, etc.):Relationship verified (birth certificates or other documentation): ☐ Yes ☐ No

Social history (relevant information regarding families of origin):

Health History (current medical problems, medications): Note: a DCF-357, "Physician's Statement for Foster Care or Adoption Applicant," must be obtained for each member of the household. The physician's examination must have been completed within the past 12 months.

Employment:

Finances (monthly income and expenses):

Criminal history (Include dates of most recent police checks:

State and FBI fingerprint-based searches must be completed prior to placement of the child in the home.):

Date Local Police check completed:	Date State Police check completed:	Date FBI check completed:

Protective services history (must be completed prior to placement of the child in the home):

Date of Protective Services Check:	Substantiation	Central Registry:
	☐ Yes ☐ No	☐ Yes ☐ No

Relationship with the birth parents (ability to set limits with the parents, willingness to permit contact):

Feelings toward the child:

The proposed guardian has a strong commitment to permanently care for the child.

Social support network (ability to utilize resources; alternative child care plans):
The proposed guardian(s) have been advised DCF will not reimburse, no fund, any services after the transfer of guardianship is granted. The family is aware while they have legal guardianship of the minor child, they can self-refer to the adoption assistance program and/or the DCF voluntary services program for consideration of needed services, provided the program/services are available.

Have day care arrangements been approved by DCF? ☐ Yes ☐ No

Name of Day Care Provider:	Provider e-mail:	Provider Phone:

Address (No. and Street):	City:	State:	Zip:

What arrangements have been made with Day Care Provider?;

Permanency Counseling: Efforts made to discuss adoption by the relative caregiver(s) as a more permanent alternative to guardianship (include explanations of the legal, financial, birth parent and visitation issues and all other efforts):
All legal option including reunification, subsidized adoption, and subsidized transfer of guardianship have been explained to and discussed with the proposed caretaker.

Reunification with the birth father is not currently a viable option due to:

Reunification with the birth mother is not currently a viable option due to:

Adoption is not currently a viable option for the child due to:

If the proposed guardian(s) has chosen not to adopt, state their reasons:

Out-of-State Caregiver(s): If the child is placed with a relative caregiver(s) who resides out of state, has the supervising state:

1. provided a current progress report regarding the child's placement? ☐ Yes ☐ No
2. agreed to the proposed transfer of guardianship to the relative caregiver(s)? ☐ Yes ☐ No

BIRTH PARENTS

1. Were efforts made to discuss the guardianship arrangement with the birth parents: ☐ Yes ☐ No
2. If efforts were made to discuss the arrangement, describe their feelings about it: If efforts were NOT made to discuss the arrangement, state why not:
3. What is the present situation; contact with the child and proposed guardian(s)]; feelings about the transfer of guardianship):

SIBLINGS

Sibling LAST Name:	Sibling FIRST Name:	Age	Sibling LAST Name:	Sibling FIRST Name:	Age

Siblings: present living situation; relationship with child and proposed guardian):

BEST INTERESTS OF CHILD

State why permanent placement with the proposed guardian is in the child's best interests:

WAIVER. If a waiver of a regulatory requirement has been granted and will be continued, specify the regulation or requirement being waived and the terms of the waiver: (Include copy of signed waiver with STOG packet)

SIGNATURES

Submitted by, SW LAST Name:	SW FIRST Name:	SW Signature	Date
Approved by, SWS LAST Name:	SWS FIRST Name:	SWS Signature	Date
Approved by, PS LAST Name:	PS FIRST Name:	PS Signature	Date

Connecticut Department of Children and Families
APPLICATION FOR GUARDIANSHIP SUBSIDY
DCF-2159
10/19 (Rev.)

PROPOSED GUARDIAN #1		PROPOSED GUARDIAN #2	
LAST Name	FIRST Name	LAST Name	FIRST Name
E-mail:	Phone #:	E-mail:	Phone #:
Relationship to Child: Please Select One		Relationship to Child: Please Select One	
Address (No. and Street):	Apartment #: / City: / State: / Zip:		

CHILD			
Child LAST Name	Child FIRST Name	DOB:	Gender: Select One or enter your own
Address (No. and Street):	Apartment #: / City: / State: / Zip:		
Date of Commitment to DCF	Date of Placement with Proposed Guardian:	Current Per Diem Rate:	

Type of Subsidy Requested: (Check all that apply)

☐ Per Diem financial subsidy _____

☐ Medical subsidy – provided by DSS Husky Program (for CT residents only)

☐ Exceptional expense – requires prior written approval by Subsidy Program Supervisor:

MEDICAL SUBSIDY: Does the child have private medical insurance through a parent or the proposed guardian? ☐ Yes ☐ No

EXCEPTIONAL EXPENSE SUBSIDY: Amount Requested: (Maximum of $2000)
Explain the nature of the expense and how it relates to the assumption of guardianship, when it was incurred, and other resources for payment which have been explored. Attach receipts or documentation of the expense and written approval by Central Office Subsidy Supervisor:

IMPORTANT LEGAL NOTICE

An applicant for, or recipient of, a guardianship subsidy from the Department of Children and Families has the right to appeal any denial, adjustment or termination of a subsidy at a DCF Administrative Hearing. At that hearing, the applicant, or the recipient, has the right to be represented by any person the applicant or recipient selects, at the applicant's or recipient's expense. You may request a hearing by writing to the DCF Administrative Hearings Unit, 505 Hudson Street, Hartford, CT 06106.

SIGNATURES (Note: Must be signed by all parties PRIOR to the Transfer of Guardianship in Superior Court for Juvenile Matters.)

I / We have received a copy of the Regulations of Connecticut State Agencies and DCF Policy regarding the Subsidized Guardianship Program.

I / We certify that the terms of this application are true and accurate to the best of my knowledge and belief.

Proposed Guardian #1 LAST Name:	Proposed Guardian #1 FIRST Name:	Proposed Guardian #1 Signature:	Date:
Proposed Guardian #2 LAST Name:	Proposed Guardian #2 FIRST Name:	Proposed Guardian #2 Signature:	Date:

DCF CERTIFICATION OF THE SUBSIDY:

☐ A monthly financial subsidy in the amount of _____, per diem, has been negotiated with the proposed guardian(s).

☐ The child is eligible for a medical subsidy.

☐ An exceptional expense subsidy is authorized for the amount of: _____

Submitted by, SW LAST Name:	SW FIRST Name:	Social Worker Signature:	Date:
Approved by, SWS LAST Name:	SWS FIRST Name:	Social Work Supervisor Signature:	Date:
Approved by, PS LAST Name:	PS FIRST Name:	Program Supervisor Signature:	Date:
Approved by OD LAST Name:	OD FIRST Name:	Office Director Signature:	Date:
Subsidy PS LAST Name:	Subsidy PS FIRST Name:	Subsidy Program Supervisor Signature:	Date:

The Department of Children and Families does NOT agree to the following subsidy(ies) as requested by the applicant:

☐ Monthly

☐ Medical

☐ Exceptional Expense

Denied by, PS LAST Name:	PS FIRST Name:	Program Supervisor Signature:	Date:

Connecticut Department of Children and Families
INITIAL AGREEMENT FOR GUARDIANSHIP SUBSIDY
DCF-418-IG
10/19 (Rev.)

For Office Use Only

The following Guardianship Subsidy Agreement has been entered into by and between the Department of Children and Families and the caregiver(s) named below for the purpose of facilitating transfer of guardianship of the child named below and to assist the caregivers in providing proper care for the child.

Caregiver #1		Caregiver #2		
LAST Name:	FIRST Name:	LAST Name:	FIRST Name:	
Address: (No. and Street):		City:	State:	Zip:
E-mail:	Phone:	E-mail:	Phone:	
Child LAST Name	Child FIRST Name	Child's DOB:	Child's Social Security #:	

Agreement

I. It is agreed that when I/we sign this Guardianship Subsidy Agreement and the guardianship is transferred, I/we am/are eligible to receive the following benefits: [Please check all applicable item(s)]:

Child is currently eligible for Social Security Benefits: ☐ Yes ☐ No If yes: ☐ SSI ☐ SSA _____ (amount per month)

☐ Monthly financial subsidy negotiated in the amount of _____ (amount per diem)

☐ Medical Subsidy (Title XIX / CT State Medicaid through Department of Social Services)

☐ Exceptional Expense Subsidy (total of non-recurring expenses associated with gaining legal guardianship (NOT to exceed $2000):

II. I/We understand that if I/we move to another state, it is my/our responsibility to apply for Title XIX/State Medicaid from the state in which we will reside. If the other state denies my/our application, payment will be provided by the Connecticut Department of Social Services.

III. I/We, as guardian(s) of the child, understand that::

A. The State of Connecticut, Department of Children and Families, will be responsible for issuing the monthly subsidy payment checks to the guardian(s) for the duration of this Agreement.
B. Should I/we move, this Agreement remains in effect, regardless of the state of my/our residence.
C. In accordance with this Agreement, the subsidies shall begin on the date that the court enters an order transferring guardianship.
D. The amount of the monthly financial subsidy is based upon my/our circumstances and the needs of the child.
E. The monthly financial subsidy and the medical subsidy can continue until the child's 18th birthday, or the child's 21st birthday if the child is in continuous full-time attendance at a secondary school, technical school or college or is in a state accredited job training program.
F. In addition to the benefits listed in Section I of this Agreement for which I/we and the child may be eligible, I/we understand that we may request information regarding additional services or changes in this Agreement by calling the Department's Subsidy Unit at 860-550-6608.
G. I/We must notify the Department of Children and Families whenever there is a change in the child's needs or the circumstances of the family that may impact the appropriate amount of the subsidy.
H. The monthly subsidy may be modified:
    a. if the needs of the child change,
    b. if the Department's foster care rate decreases (a subsidy cannot exceed the prevailing foster care rate), and
    c.. if the circumstances of the guardian(s) change
I. An annual review will be conducted by the Department of Children and Families to assess my/our circumstances and the needs of the child to determine whether there is reason to continue or modify the amount and/or duration of the financial subsidy.
j. This Agreement will be renewed annually by me/us and the Department. If I/we do not submit the annual renewal Agreement to the Department of Children and Families by the specified due date, the subsidies may be subject to termination.
K. Termination of this Agreement will occur:
    a. if I/we are no longer responsible for providing financial support for the child for any reason including, but not limited to, the return of the child to the child's parents;
    b. when the child reaches age eighteen (18), or age twenty-one (21) if the child is in full-time attendance at a secondary school, technical school or college or is in a state accredited job training program;
    c. in the event of my/our death(s) or the death of the child; or
    d. if I/we no longer have physical or legal custody of the child.
L. I understand that the child is solely my/our legal responsibility. My/our family, including the child, is independent of the Department except for those obligations outlined in this Agreement.

IV.

A. I/We agree to notify the Department of Children and Families in writing in the event I/we am/are no longer responsible for the support of the child or if the child is no longer living with me (us).

B. I/We agree that the monthly subsidy payment may never exceed the prevailing foster care rate paid by the Department of Children and Families as applicable for this child's age and special needs.

C. I/We agree that if/when the child has attained the minimum age for compulsory school attendance, the child will be enrolled in and attend a full-time elementary or secondary school program or be instructed pursuant to a home school or independent study program that conforms to the law of the state in which the child is living, unless the child has completed a secondary school program or is incapable of attending due to a medical condition. I/we will provide confirmation of the educational circumstances of the child to the Department of Children and Families at each annual review.

D. The Department of Children and Families agrees to notify me/us in writing of any reduction or termination in the amount of the guardianship subsidy payments at least fourteen (14) days prior to taking such action. I/We understand that we may request a hearing to challenge this action.

E. The Department of Children and Families agrees to notify me/us in writing forty-five (45) days before the date of annual renewal and to include the appropriate forms with the renewal notice.

V. I/We have been advised by the Department of Children and Families of my/our right to appeal to the Administrative Hearings Unit if I/we disagree with the Department of Children and Families' decision regarding this Agreement or any renewal Agreement or any other action that affects status of the subsidies I/we are receiving. I/We understand that I/we may request an appeal hearing by writing to the:

Department of Children and Families Administrative Hearings Unit, 505 Hudson Street, Hartford, CT 06106, DCF.Appeals@ct.gov

I/We understand that I/we have the right to be represented at the hearing by legal counsel at my/our own expense and to receive a timely notice of the date, place and time of the hearing.

VI. The effective date of this Agreement is the date of transfer of guardianship. Anticipated Date of Transfer of Guardianship:

VII. In the case of the death, severe disability or serious illness of a caregiver who is receiving a guardianship subsidy, the commissioner may transfer the guardianship subsidy to a successor guardian who meets the department's foster care safety requirements. A new agreement must be executed between DCF and the successor guardian. I/We hereby name the following person(s) to be the successor guardian(s) of the Child (or Children).

Successor Guardian #1		Successor Guardian #2		
LAST Name:	FIRST Name:	LAST Name:	FIRST Name:	
Address: (No. and Street):		City:	State:	Zip:
E-mail:	Phone:	E-Mail:	Phone:	

Comments/Notes/Additional Information *(if needed)*

Signatures

Signature of Caregiver #1	Date:
Signature of Caregiver #2	Date:
Signature of DCF Program Supervisor (or designee)	Date:

For questions contact the DCF Subsidy Unit: 860-550-6608

Connecticut Department of Children and Families
TITLE IV-E GUARDIANSHIP SUBSIDY APPLICATION
DCF-552-G
2/19 (Rev.)

Revenue Enhancement Division Use Only			
OLD EMS:		NEW EMS:	
IV-E:	☐ Yes	☐ No	
EW:		Date:	

Date:	LINK Case #:	LINK Person ID#:		Date Finalized:	Per Diem Subsidy Amount:
Child LAST Name	Child FIRST Name	DOB:	Gender: Select One or enter your own		
Race: Please Select One	Ethnicity: Please Select One	SS#:	Check one box only: ☐ Financial & Medical Subsidy ☐ Financial Subsidy Only ☐ Medical Subsidy Only		
SW LAST Name	SW FIRST Name	DCF Office: Select DCF Office		SW Phone:	

PROPOSED GUARDIAN #1		PROPOSED GUARDIAN #2	
LAST Name:	FIRST Name:	LAST Name:	FIRST Name:
Guardian #1 E-Mail:	Guardian #1 Phone #:	Guardian #2 E-mail:	Guardian #2 Phone #:

Proposed Guardian's Address (No. and Street):	Apartment #:	City:	State:	Zip:

PLEASE RESPOND TO THE FOLLOWING QUESTION BY CHECKING THE APPROPRIATE BOX AND PROVIDING ADDITIONAL INFORMATION AS NEEDED

Is there a written guardianship subsidy agreement between the Department and the guardian signed prior to finalization of the Transfer of Guardianship? ☐ Yes ☐ No

DECLARATION OF CITIZENSHIP OR ALIEN STATUS / SOCIAL WORKER CERTIFICATION

Under penalty of perjury, I the undersigned, declare that:

☐ This dependent child is a United Stated citizen

☐ This dependent child is an alien, currently registered with the Immigration and naturalization Service (INS) and is legally authorized to be in the United States.

I completed this form as a representative of the Department of Children and Families, which is responsible for the care of this child and certify that the information given on this form is true and complete to the best of my knowledge.

SW LAST Name:	SW FIRST Name:	SW Signature:	Date: