MISSOURI DEPARTMENT OF SOCIAL SERVICES
DIVISION OF FAMILY SERVICES

APPLICATION AND AGREEMENT FOR PAYMENT OF NONRECURRING ADOPTION EXPENSES

PLEASE PRINT

APPLICATION	FOR DFS USE ONLY	
APPLICANT NAME (FIRST, MIDDLE, LAST)	VENDOR DVN	
APPLICANT NAME (FIRST, MIDDLE, LAST)	CONTRACT NUMBER	
ADDRESS (STREET OR P.O. BOX, CITY, STATE, ZIP)	COUNTY	COUNTY CODE

- I (We) am applying to the Department of Social Services, Division of Family Services (hereinafter “Division”) for payment of reasonable and customary nonrecurring adoption expenses of up to $2,000 per child for the adoption of the special needs child(ren) listed below.
- I (We) understand that payment will not be made until a copy of the adoption decree has been received and proof of incurred costs is received by the Division.
- I (We) understand that if I (We) do not agree with the decision made by the Division regarding this application, I (We) have the right to appeal the decision. I (We) may request a fair hearing under the Division’s current and applicable hearing procedures and policies.
- I (We) understand that some of the non-identifying information required by this application will be reported to the Adoption and Foster Care Analysis and Reporting System according to AFCARS Final Rule (Federal Register, Vol. 58. No. 244, Dec. 22, 1993, pp. 67912-67938.)

CHILD(REN)’S DEMOGRAPHICS, ELIGIBILITY, AND DOCUMENTATION OF SPECIAL NEEDS

CHILD INFORMATION	CHILD 1	CHILD 2	CHILD 3	CHILD 4
NAME (FIRST AND MIDDLE ONLY)				
SEX (CHECK APPROPRIATE BOX)	☐ MALE ☐ FEMALE	☐ MALE ☐ FEMALE	☐ MALE ☐ FEMALE	☐ MALE ☐ FEMALE
DATE OF BIRTH (MM/DD/CCYY)	__ __ / __ __ / __ __ __ __	__ __ / __ __ / __ __ __ __	__ __ / __ __ / __ __ __ __	__ __ / __ __ / __ __ __ __
RACE (CHECK APPROPRIATE BOX) (Use Unable to Determine only if the child is very young or severely disabled and no person is available to determine the child’s race.)	☐ WHITE ☐ BLACK ☐ AMERICAN INDIAN/ALASKAN NATIVE ☐ ASIAN/PACIFIC ISLANDER ☐ UNABLE TO DETERMINE	☐ WHITE ☐ BLACK ☐ AMERICAN INDIAN/ALASKAN NATIVE ☐ ASIAN/PACIFIC ISLANDER ☐ UNABLE TO DETERMINE	☐ WHITE ☐ BLACK ☐ AMERICAN INDIAN/ALASKAN NATIVE ☐ ASIAN/PACIFIC ISLANDER ☐ UNABLE TO DETERMINE	☐ WHITE ☐ BLACK ☐ AMERICAN INDIAN/ALASKAN NATIVE ☐ ASIAN/PACIFIC ISLANDER ☐ UNABLE TO DETERMINE
HISPANIC ORIGIN - Regardless of race, is the child of Mexican, Puerto Rican, Cuban, Central or South American, or other Spanish cultural origin? (Use Unable to Determine only if the child is very young or severely disabled and no person is available to determine whether or not the child is Hispanic.)	☐ YES ☐ NO ☐ UNABLE TO DETERMINE	☐ YES ☐ NO ☐ UNABLE TO DETERMINE	☐ YES ☐ NO ☐ UNABLE TO DETERMINE	☐ YES ☐ NO ☐ UNABLE TO DETERMINE

CHILD INFORMATION	CHILD 1	CHILD 2	CHILD 3	CHILD 4
SPECIAL NEEDS - Enter the appropriate code(s) describing a special need(s) for each child for whom application is made. **If more than one applies, circle the one which creates the primary concern for placement.**				
1. Minority Racial/Ethnic Heritage 2. Five Years of Age or Older 3. Member, Sibling Group (adopted in same petition) 4. Medical Conditions or Mental, Physical, or Emotional Disabilities 5. Other Special Needs which Hindered Adoptive Placement; specify				
MEDICAL CONDITIONS - If the child has medical special needs (#4 above) indicate the conditions that apply and **attach a statement from a physician, psychologist, social worker, or psychiatrist describing the child's condition or other needs that hindered the child's adoptive placement.** (Check one or more.)	☐ PHYSICALLY DISABLED ☐ EMOTIONALLY DISABLED ☐ MENTAL RETARDATION ☐ VISUALLY OR HEARING IMPAIRED ☐ OTHER MEDICALLY DIAGNOSED CONDITION REQUIRING SPECIAL CARE	☐ PHYSICALLY DISABLED ☐ EMOTIONALLY DISABLED ☐ MENTAL RETARDATION ☐ VISUALLY OR HEARING IMPAIRED ☐ OTHER MEDICALLY DIAGNOSED CONDITION REQUIRING SPECIAL CARE	☐ PHYSICALLY DISABLED ☐ EMOTIONALLY DISABLED ☐ MENTAL RETARDATION ☐ VISUALLY OR HEARING IMPAIRED ☐ OTHER MEDICALLY DIAGNOSED CONDITION REQUIRING SPECIAL CARE	☐ PHYSICALLY DISABLED ☐ EMOTIONALLY DISABLED ☐ MENTAL RETARDATION ☐ VISUALLY OR HEARING IMPAIRED ☐ OTHER MEDICALLY DIAGNOSED CONDITION REQUIRING SPECIAL CARE
BIRTH MOTHER YEAR OF BIRTH (CCYY)	__ __ __ __	__ __ __ __	__ __ __ __	__ __ __ __
BIRTH FATHER YEAR OF BIRTH (CCYY)	__ __ __ __	__ __ __ __	__ __ __ __	__ __ __ __
WAS BIRTH MOTHER MARRIED AT THE TIME OF CHILD'S BIRTH? (Use Unable to Determine only if the child was abandoned and no information was available on the mother.) (CHECK)	☐ YES ☐ NO ☐ UNABLE TO DETERMINE	☐ YES ☐ NO ☐ UNABLE TO DETERMINE	☐ YES ☐ NO ☐ UNABLE TO DETERMINE	☐ YES ☐ NO ☐ UNABLE TO DETERMINE
DATE OF TERMINATION OF PARENTAL RIGHTS - MOTHER (IF MOTHER IS DECEASED, ENTER DATE OF DEATH) (MM/DD/CCYY)	__ __ / __ __ / __ __ __ __	__ __ / __ __ / __ __ __ __	__ __ / __ __ / __ __ __ __	__ __ / __ __ / __ __ __ __
DATE OF TERMINATION OF PARENTAL RIGHTS - FATHER (IF FATHER IS DECEASED, ENTER DATE OF DEATH) (MM/DD/CCYY)	__ __ / __ __ / __ __ __ __	__ __ / __ __ / __ __ __ __	__ __ / __ __ / __ __ __ __	__ __ / __ __ / __ __ __ __

ADOPTIVE PARENT(S)' DEMOGRAPHICS AND ADOPTION DETAILS

	CHILD 1	CHILD 2	CHILD 3	CHILD 4
ADOPTIVE PARENT PRIOR RELATIONSHIP WITH THE CHILD (CHECK APPROPRIATE BOX)	☐ RELATIVE BY BIRTH OR MARRIAGE ☐ NON-RELATIVE FOSTER PARENT ☐ NONE	☐ RELATIVE BY BIRTH OR MARRIAGE ☐ NON-RELATIVE FOSTER PARENT ☐ NONE	☐ RELATIVE BY BIRTH OR MARRIAGE ☐ NON-RELATIVE FOSTER PARENT ☐ NONE	☐ RELATIVE BY BIRTH OR MARRIAGE ☐ NON-RELATIVE FOSTER PARENT ☐ NONE

ADOPTIVE PARENT INFORMATION	ADOPTIVE MOTHER	ADOPTIVE FATHER
DATE OF BIRTH (MM/DD/CCYY)	__ __ / __ __ / __ __ __ __	__ __ / __ __ / __ __ __ __
RACE (CHECK APPROPRIATE BOX)	☐ WHITE ☐ BLACK ☐ AMERICAN INDIAN ALASKAN NATIVE ☐ ASIAN/PACIFIC ISLANDER	☐ WHITE ☐ BLACK ☐ AMERICAN INDIAN ALASKAN NATIVE ☐ ASIAN/PACIFIC ISLANDER
HISPANIC ORIGIN - Regardless of race, is the person of Mexican, Puerto Rican, Cuban, Central or South American, or other Spanish cultural origin? (Check appropriate box	☐ YES ☐ NO	☐ YES ☐ NO
ADOPTIVE FAMILY STRUCTURE (CHECK ONE)	☐ MARRIED COUPLE ☐ UNMARRIED COUPLE	☐ SINGLE FEMALE ☐ SINGLE MALE
AT THE TIME OF INITIATION OF THE ADOPTION PROCEEDINGS, THE INDIVIDUAL OR AGENCY THAT HAD CUSTODY OR RESPONSIBILITY FOR THE CHILD(REN) WAS LOCATED IN:	☐ MISSOURI ☐ ANOTHER STATE	☐ ANOTHER COUNTRY (PRIOR TO THE ADOPTIVE PLACEMENT, THE CHILD WAS RESIDING IN ANOTHER COUNTRY AND WAS NOT A U.S. CITIZEN)
INDIVIDUAL OR AGENCY WHICH PLACED THE CHILD FOR ADOPTION	☐ PUBLIC AGENCY (UNIT OF STATE OR LOCAL GOVERNMENT) ☐ TRIBAL AGENCY (A UNIT WITHIN ONE OF THE FEDERALLY RECOGNIZED INDIAN TRIBES OR INDIAN TRIBAL ORGANIZATIONS)	☐ PRIVATE AGENCY (FOR-PROFIT OR NON-PROFIT) ☐ INDEPENDENT PERSON (DOCTOR, LAWYER, OR SOME OTHER INDIVIDUAL)

Payment of nonrecurring adoption expenses is needed/required for one of the following reasons: (Check one and provide the required documentation. The agency or other intermediary which facilitated the child's placement must provide you with information that documents the efforts made to place the child without need for payment of nonrecurring adoption expenses.)

☐ I (We) was a foster/relative family for this child(ren) and require assistance with the nonrecurring adoption expenses. (Attach documentation showing your foster/relative family relationship to the child(ren) immediately before the date of the adoption petition filing.)

☐ A family was not readily available and a reasonable, but unsuccessful effort, was made to find a family who would not need assistance with nonrecurring adoption expenses. (Attach a written description of the effort made to find a family who would **not** need assistance.)

	ADOPTIVE MOTHER SIGNATURE ▶	DATE	ADOPTIVE FATHER SIGNATURE ▶	DATE
REPRESENTATIVE OF CHILD PLACING AGENCY, DIVISION OF YOUTH SERVICES OR DEPARTMENT OF MENTAL HEALTH (IF APPLICABLE)	NAME	TITLE	SIGNATURE ▶	DATE
NAME OF AGENCY		ADDRESS		

ELIGIBILITY DECISION AND AGREEMENT (FOR DFS USE ONLY)

	CHILD 1	CHILD 2	CHILD 3	CHILD 4
Child meets all the eligibility requirements	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO
Explain any boxes checked "No"				

The Department of Social Services, Division of Family Services, State of Missouri agrees to pay reasonable and customary nonrecurring adoption expenses of up to $2,000 per child for the legal proceedings and other adoption process costs as will be listed in the "Request for Payment" which are related to the adoption of a child(ren) listed above who has been determined eligible. Payment will be made when the adoption is final and proof of the adoption and proof of expenses are received.

REVIEW AND APPROVAL (FOR DFS USE ONLY)

CHILDREN'S SERVICES WORKER NAME (PRINT)	SIGNATURE ▸	DATE
CHILDREN'S SERVICE SUPERVISOR NAME (PRINT)	SIGNATURE ▸	DATE
AREA DIRECTOR/DESIGNEE NAME (PRINT)	SIGNATURE ▸	DATE
DIVISION DIRECTOR NAME (PRINT)	SIGNATURE ▸	DATE

REQUEST FOR PAYMENT OF NONRECURRING ADOPTION EXPENSES

(This section must be completed and submitted once the adoption is final. Please submit a copy of the adoption decree and proof of all eligible nonrecurring adoption expenses.)

As agreed by myself (ourselves) and the Division, reasonable and customary charges for the nonrecurring adoption expenses are submitted for payment. I (We) have attached proof of incurred expenses ("paid" receipt or invoice from provider) and proof of the child(ren)'s adoption.

(Enter the amount for each expense you are requesting. If any of the expenses include services for more than one child, divide the expenses equally among all the children. The total amount must not exceed $2,000 per child.)

SERVICES	CHILD 1	CHILD 2	CHILD 3	CHILD 4
Legal costs related to the adoption for the court filing, publication, attorney, and Guardian ad litem fees.	$			
Adoptive Family Assessment (home study)	$			
Supervision of the placement until the adoption decree was granted, if not included in the price of the Adoptive Family Assessment.	$			
Health or psychological examinations required to complete the Adoptive Family Assessment.	$			
Transportation, food, and lodging expenses for you and the child(ren), necessary to complete the adoption.	$			
TOTAL	$			

ADOPTIVE PARENT SIGNATURE ▸ DATE	ADOPTIVE PARENT SIGNATURE ▸ DATE

FOR DIVISION OF FAMILY SERVICES USE ONLY

		CHILD 1	CHILD 2	CHILD 3	CHILD 4
NAME					
DCN					
APPROVED PAYMENT AMOUNT	LEGAL	$			
	OTHER	$			

COMMENTS

DFS CHILDREN'S SERVICES WORKER NAME (PRINT)	SIGNATURE ▶	DATE

DFS SUPERVISORY REVIEW AND APPROVAL (FOR DFS USE ONLY)

NAME (PRINT)	TITLE	SIGNATURE ▶	DATE
ADOPTION GRANTED (DATE)	ADOPTION DECREE RECEIVED (DATE)	EXPENSES RECEIPTS RECEIVED (DATE)	