ADOPTION ASSISTANCE PROGRAM (AAP) AGREEMENT

NOTICE: This agreement describes the adoption assistance benefit that you will receive for your adopted child. If you agree, please sign the agreement and return it to the adoption agency. If you disagree, please contact the adoption agency. If you and the agency cannot reach an agreement, you will receive a Notice of Action which explains how to request a state hearing to resolve the matter.

☐ Title IV-E Federal Eligible ☐ State Only Eligible ☐ County Only Eligible

I/We,_____ and_____, have entered into an
(NAME OF PARENT) (NAME OF PARENT)

agreement with the_____for
(NAME, ADDRESS, TELEPHONE NUMBER OF RESPONSIBLE PUBLIC AGENCY)

an adoption assistance benefit for_____.
(NAME OF CHILD)

AAP eligibility is expected to continue from _____until_____. This
(DATE OF ADOPTIVE PLACEMENT) (EXPECTED ENDING DATE OF ELIGIBILITY)

agreement is effective until terminated in accordance with its terms or a new amended agreement is signed.

This is *(check one)* ☐ a deferred agreement *(complete Section II only.)*
☐ an initial agreement
☐ an amendment to the agreement dated _____.
(DATE OF INITIAL AGREEMENT)

Complete Section I or II as appropriate.

SECTION I

1. An AAP benefit of $ _____ per month and/or Medi-Cal is authorized to begin _____.
(AMOUNT) (BEGINNING DATE OF PAYMENT)
The child's needs must be reassessed periodically, at least every two years. The first scheduled reassessment is_____.
(FIRST REASSESSMENT DATE)

2. Unless the benefit is ending because of age, _____ will send me/us
(COUNTY WELFARE DEPARTMENT)
a Reassessment Information - Adoption Assistance Program *(AAP 3)* form at least 60 days before the next reassessment date. I/We shall complete the AAP 3 and return it to the _____.
(RESPONSIBLE PUBLIC AGENCY)

3. With my/our agreement, the responsible public adoption agency in accordance with state law may increase or decrease the amount of the AAP benefit as my/our circumstances or the needs of the child change.

4. For initial agreements signed prior to January 1, 2010, my child **may** be eligible for an age-related increase after his or her 5th, 9th, 12th and 15th birthdays. In Marin County, the age related increase occurs after his or her 5th, 7th, 9th, 12th, 13th and 15th birthdays. I/We **shall** contact the adoption agency to request this increase.

5. The AAP benefit may not exceed the age-related, state-approved foster family home care rate, and any applicable state-approved Specialized Care Increment (SCI), or, if my child is temporarily placed outside the home, the state approved facility rate which would have been paid if the child had not been placed for adoption.

6. Due to a change in my child's special needs and/or placement which may cause the AAP benefit amount to exceed the foster care payment amount he or she would have received had he or she remained in foster care, the AAP benefit may be reduced.

7. If the child is under the age of three and receiving services under the California Early Intervention Services Act, but not yet determined by the Califiornia Regional Center (CRC) to have a developmental disability as defined by the Lanterman Act, the maximum AAP benefit will either be the current fiscal year (July 1st through June 30th) dual agency rate for a child three years and younger or the foster family home rate and applicable SCI rate, whichever is greater. After the adoption finalization, it is my/our responsibility to request the CRC to evaluate the child's eligibility for CRC services. If the child is eligible to receive CRC services beyond the age of three, it is my/our responsibility to request the dual agency rate from the responsible public agency.

   I/We agree, prior to the month following the child's third birthday, if the child is no longer eligible for CRC services, the AAP benefit will need to be renegotiated based on the foster family home rate and any applicable SCI rate.

   If the child is under the age of three and the CRC has determined the child to have a developmental disability as defined by the Lanterman Act, the maximum AAP benefit is the current fiscal year (July 1st through June 30th) dual agency rate for a child three years and older, there is no supplement to this rate.

8. If the child is a current consumer of CRC services, the maximum available AAP benefit is the current fiscal year (July 1st through June 30th) dual agency rate for a child three years and older (dual agency rate and eligible supplement to the rate not to exceed $1,000). CRC consumers who have received a rate prior to July 2007, which exceeds the maximum eligible dual agency rate for the current fiscal year (July 1st through June 30th) for a child three years and older plus supplement to the rate may continue to receive the higher rate until the child is no longer eligible for AAP benefits or the adoption is dissolved.

9. I/We agree the AAP benefit of $ _____ will be directed to _____ for payment of
   (AMOUNT) (NAME OF FACILITY)
   out-of-home placement/Wraparound services for our child.

   The AAP payment is authorized from _____ to _____.
   (BEGINNING DATE) (END DATE)

   I/We understand the AAP payment is not to exceed the maximum state-approved facility rate for which our child is eligible.

   I/We agree in the month following the stated end date or if different, the date the child's out-of-home placement/Wraparound services ends, the AAP benefit will be changed to the negotiated foster family home rate, applicable SCI rate or Dual Agency rate.

   I/We understand the AAP payment for the out-of-home placement/Wraparound services may not exceed 18 months per episode or condition.

   ☐ I/We request the AAP payment be made directly to _____ .
   (NAME OF FACILITY)

   ☐ I/We agree to pay the _____ directly with the AAP funds received.
   (NAME OF FACILITY)

   ☐ I/We request two checks be issued one check in the amount of $ _____to the_____
   (NAME OF FACILITY/PROVIDER)
   and one check in the amount of $_____ to _____ .
   (NAME OF ADOPTIVE PARENT [S])

10. I/We understand that AAP benefit will continue unless one of the following occurs:
    a. The child has attained the age of 18 or 21.
    b. I/We are no longer legally responsible for the support of the child.
    c. I/We are no longer providing any type of support to the child.

11. I/We agree to inform the responsible public agency immediately if any of the following occurs:
    a. Change in mailing address and/or state of residence.
    b. The child is no longer residing in the family home.
    c. We are no longer providing any type of support to the child.
    d. We are no longer legally responsible for the support of the child.

    Failure to report these changes may result in an overpayment which may be recovered by a direct charge or a reduction in current and future AAP benefits.

12. I/We understand that _____ will remain eligible to receive an AAP benefit from the
(NAME OF CHILD)

State of California regardless of the state in which I/we reside. If a needed service is not available in my/our state of residence, the _____ remains financially responsible for the needed services.
(FINANCIAL RESPONSIBLE COUNTY OF ORIGIN)

13. ☐ I/We understand that under the terms of this agreement the child is eligible for Title IV-E (federal) AAP benefits and services under Title XIX (Medicaid) and Title XX (Social Services) of the Federal Social Security Act. _____ will help the child obtain these services by providing information and referral
(RESPONSIBLE PUBLIC AGENCY)

services, if I/we live in or move to another state.

☐ I/We understand that under the terms of this agreement the child is eligible for State AAP benefits and State funded Medi-Cal services, and _____ will help the child obtain medical services by
(RESPONSIBLE PUBLIC AGENCY)

providing information and referral services, if I/we live in or move to another state. Through this agreement, I/we understand access to health care services for our child will be contingent on whether our current or future state of residence extends COBRA-reciprocity to children receiving California state funded Medi-Cal benefits. This means if I/we move to a state that does not have an agreement with California, I/we may not be able to obtain health care coverage for our child through that state's Medicaid program based on our receipt of AAP.

14. I/We understand that the child will not be eligible to receive an AAP benefit after he or she reaches the age of 18 years **unless** he or she has a mental or physical disability which warrants continuation to the age of 21 years. Prior to the child's 18th birthday, I/we are to inform the responsible public agency and request they evaluate our child's needs for continuation of benefits beyond the age of 18.

15. I/We understand that the child will not be eligible to receive an AAP benefit after he or she reaches the age of 18 years **unless** the initial agreement was signed when the child was at least 16 years of age and the child will be age 18 on or after January 1, 2012; and one of the following five participation criteria is met:

    1. Completing a high school or an equivalency program; or
    2. Enrolled in a post-secondary or vocational school; or
    3. Participating in a program or activity that promotes or removes barriers to employment; or
    4. Is employed at least 80 hours per month; or
    5. Is incapable of participating in 1 through 4 above, due to a mental or physical disability.

    I/We are responsible for requesting the benefit extension prior to the child's 18th birthday, and providing documentation to the responsible public agency supporting that the child meets one of the five participation criteria.

16. I/We understand that the child's basic foster family home rate may be automatically increased based on the annual California Necessities Index (CNI) increase should one occur, effective July 1st. I/We understand that the responsible public agency will send a Notice of Action reflecting the basic foster family home rate change due to the CNI increase.

SECTION II *(Deferred Agreement)*

I/We understand that_____is AAP eligible and although assistance is not needed at
(NAME OF CHILD)
this time, I/we understand that at anytime, I/we may request AAP benefits.

SECTION III SIGNATURE

ADOPTIVE PARENT:	DATE:	ADOPTIVE PARENT:	DATE:
CHILD'S AGENCY REPRESENTATIVE:	DATE:	CHILD'S AGENCY NAME:	
FAMILY'S AGENCY REPRESENTATIVE (CO-OP PLACEMENT ONLY):	DATE:	FAMILY'S AGENCY NAME:	