STATE OF CALIFORNIA - HEALTH AND HUMAN SERVICES AGENCY

CALIFORNIA DEPARTMENT OF SOCIAL SERVICES

# PAYMENT INSTRUCTIONS
# ADOPTION ASSISTANCE PROGRAM

**DISTRIBUTION:**
*Original : County Welfare Department*
*Copy : Agency File*

AAP PAYMENT CASE NUMBER

STATE ADOPTIONS CASE NUMBER

ADA

ADOPTION AGENCY CASE NUMBER

CHILD'S ADOPTIVE NAME

CHILD'S BIRTHDATE

Adoption Finalization Date: _____

Date initial AAP Agreement (AD 4320) was signed: _____

This is a: *(Check applicable items)* Please send Notice of Action for the following checked items.

- ☐ New case; Form AAP 4, Eligibility Certification - Adoption Assistance Program is attached, please send Notice of Action.
- ☐ Denial, please send Notice of Action.
- ☐ Deferred payment agreement, please send Notice of Action.
- ☐ Change in child's name, payee name or address.
- ☐ Overpayment requiring collection.

Reason for the denial, termination or overpayment to be stated on the Notice of Action: _____

_____

- ☐ Change in amount or duration of payment due to: *(Check (✔) one)*
  - ☐ Completed reassessment.
  - ☐ Change in need or circumstances.
  - ☐ Case Terminated.
  - ☐ Benefit Extension
    - ☐ Child/Youth has a mental or physical disability
    - ☐ Child/Youth meets one of the five participation criteria per Welfare and Institutions Code Section 11403(b)(1) through (5)

Please start or change payments as follows:

Total monthly payment amount: ☐ $ _____ or ☐ No cash payment, Medi-Cal only

The following checked rate structure equals the total monthly payment amount:

- ☐ AAP Basic Rate: $ _____
- ☐ Dual Agency Rate: $ _____
- ☐ Rate Classification Level (RCL): _____
- ☐ Specialized Care Increment: $ _____
- ☐ Supplemental Rate: $ _____
- ☐ State Approved Facility Rate: $ _____

Start date: _____ Date of Reassessment: _____

**If applicable, check one:**

- ☐ The child is placed outside of the adoptive home:
  Name of the out-of-home placement facility: _____
  - ☐ One check to be issued to the facility.
  - ☐ One check to be issued to the adoptive parent who will directly pay the facility.
  - ☐ Two checks to be issued:
    $ _____ to be paid to the facility
    $ _____ to be paid to the adoptive parent
- ☐ The child is eligible to receive Wraparound services:
  Name of Wraparound provider: _____
  - ☐ One check to be issued to the provider.
  - ☐ Two checks to be issued:
    $ _____ to be paid to the Wraparound provider
    $ _____ to be paid to the adoptive parent

Health Insurance

- ☐ The family reports that the child has no health insurance.
- ☐ The family reports that the child has health insurance with: _____

PAYEE(S) NAME

AND

PAYEE(S) ADDRESS (NO.) (STREET)

(CITY) (STATE) (ZIP)

PAYEE(S) TELEPHONE NUMBER

PAYEE(S) EMAIL ADDRESS

SIGNATURE OF AUTHORIZED OFFICIAL OF ADOPTION AGENCY ▶

ADOPTION AGENCY MAILING ADDRESS

TELEPHONE NUMBER

DATE