NOTICE OF FORM CHANGE NO. 04-175

DATE: 06/22/2004

TO:
County Welfare Director
Supply Clerk / Forms Coordinator

FROM:
Forms Management Unit
(916) 657-1907

- ☐ Community Care Licensing District Offices
- ☒ Private and Public Adoption Agencies
- ☐ District Attorney
- ☐ Other

Listed below is information regarding a form change. Only applicable information is shown.

This notice updates your Department of Social Services County Forms Catalog.

FORM NUMBER AND TITLE: AAP 2 (8/01) - PAYMENT INSTRUCTIONS ADOPTION ASSISTANCE PROGRAM

ORDER UNIT		ESTIMATED PRICE	INITIAL SUPPLY SENT
MASTER ONLY	☒ Free ☐ Sold		☐ Yes ☒ No
☐ New ☐ Revised	DATE OF FORM: 8/01	REPLACES	☐ Obsolete

REQUIRED FORM-
☒ No Change Permitted ☐ Substitute Permitted With Prior DSS Approval ☐ Recommended Form

UNLESS OTHERWISE SPECIFIED STOCK MAINTAINED AT:
Department of Social Services Warehouse
P.O. Box 980788
West Sacramento, CA 95798-0788

☐ Other:

FORMS DISPOSITION AND SPECIAL INSTRUCTIONS

DISPOSITION OF OLD SUPPLY
☒ Use until exhausted ☐ Destroy

USE NEW FORM
☐ When supply available in DSS Warehouse ☒ Use new form effective 8/01

USE FORM IN ACCORDANCE WITH
☐ All County Letter No.
☐ Other (specify)

ADDITIONAL INFORMATION REGARDING FORM CHANGE
FORM IS NOW A MASTER ONLY.

Attached is a Reproducible Copy. Print 8 1/2 x 11.

Check on the internet to see if forms are available at www.dss.cahwnet.gov

For camera-ready copies of English form, please call the Forms Management Unit (FMU) at (916) 657-1907, or by electronic mail at: fmudss@dss.ca.gov.

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

This is a: *(Check applicable item(s))*

- ☐ 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.
- ☐ Change in amount or duration of payment due to: *(Check (✔) one)*
  - ☐ Completed reassessment.
  - ☐ Change in need or circumstances.
  - ☐ Ineligibility.

Reason for change or denial to be used on notice of action: _____

_____

I certify that this child is eligible for the Adoption Assistance Program. Please start or change payments as follows:

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

Beginning date:_____ Ending date:_____

Check one:

☐ This monthly payment amount is not greater than the payment that would have been made if the child were placed in a foster family home.

The payment that would have been made in a foster family home, including any applicable specialized care increment: $_____ per month.

☐ The child is placed outside of the adoptive home and the monthly payment amount is no greater than the AFDC-FC payment that would have been made if the child were a foster child in the out of home placement.

Name of out of home placement: _____

State-approved facility rate: $_____ per month.

Health Insurance

- ☐ The family reports that the child has no health insurance.
- ☐ The family reports that the child has health insurance with:_____, Department of Health Services Health Insurance Questionnaire (Form DHS 6155) is attached.)

PAYEE NAME			SIGNATURE OF AUTHORIZED OFFICIAL OF ADOPTION AGENCY * ▶	
PAYEE ADDRESS (NO.)		(STREET)	ADOPTION AGENCY MAILING ADDRESS	
(CITY)	(STATE)	(ZIP)		
PAYEE TELEPHONE			TELEPHONE NUMBER	DATE

* To be used by child' s agency for cooperative placements.