

## Source of Funds Application for Child in Placement

CHILD'S NAME		CHILD'S CASE NUMBER		DATE PLACED	
DSHS STAFF NAME AND TITLE		TELEPHONE NUMBER		DATE COMPLETED	
<p>1. Was child living with either or both parents during the month the petition was filed or Voluntary Placement Agreement (VPA) signed? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If yes, is the home from which the child was removed receiving AFCD benefits on behalf of the child? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Case number: _____</p> <p>If no, where was the child living during the last six months prior to placement: _____</p>					
2. Order of removal:					
DATE OF ACTION	TYPE OF ACTION (SHELTER CARE, DEPENDENCY, ARP, VPA)		COURT ORDER NUMBER	AGENCY TO WHOM THE COURT AWARDED CUSTODY / SUPERVISION	
3. Is the home from which the child removed receiving adoption support payments from Washington State? <input type="checkbox"/> Yes <input type="checkbox"/> No					
4. Is the child certified as eligible for developmental disability services by the Division of Developmental Disabilities (DDD)? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, attached documentation.					
5. Does the child have medical and/or dental insurance? <input type="checkbox"/> Yes (list below) <input type="checkbox"/> No OR the child has medical coupons.					
NAME OF INSURANCE COMPANY		NAME OF POLICY HOLDER		TYPE OF COVERAGE	POLICY NUMBER
6. FINANCIAL INCOME / RESOURCES FOR CHILD AND PARENT(S)					
INCOME SOURCE	FATHER	MOTHER	STEP PARENT	CHILD	
1. SSI					
2. AFDC					
3. Check one. <input type="checkbox"/> SSA <input type="checkbox"/> VA <input type="checkbox"/> L&I					
4. Child support					
5. Earned income (wages) or unemployment compensation					
6. Retirement					
7. Other (bank account, etc.)					
<b>IV-E Specialists Use Only</b>					
1. Status of child: <input type="checkbox"/> DCFS not DDD <input type="checkbox"/> DCFS certified DDD <input type="checkbox"/> JRA not DDD		4. Date sent to DCS: 1 <sup>st</sup> referral _____ 2 <sup>nd</sup> referral _____			
2. Date of placement: _____		5. Date sent to Medical Recover: _____			
3. Source of funds: <input type="checkbox"/> State only – Court <input type="checkbox"/> State only – Voluntary		<input type="checkbox"/> IV-E – Court <input type="checkbox"/> IV-E – Voluntary			
7. REUNIFICATION PLAN					
A. <u>Initial referral</u>					
Is there a court ordered plan? <input type="checkbox"/> Yes (Court order attached) <input type="checkbox"/> No					
Is there a plan as part of a voluntary placement? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Parent's name: _____					
Duration of plan: _____ TO _____ FROM _____					
Anticipated monthly cost to parent: \$ _____					
Will compliance cause parent to become unemployed or significantly underemployed? <input type="checkbox"/> Yes <input type="checkbox"/> No					
B. <u>Subsequent referral information</u>					
<input type="checkbox"/> Court ordered parents to participate in a reunification plan. Court order attached. Anticipated monthly cost to parent: \$ _____					
Duration of plan: _____ TO _____ FROM _____					
Will compliance cause parent to become unemployed or significantly underemployed? <input type="checkbox"/> Yes <input type="checkbox"/> No					
<input type="checkbox"/> Court did not order a reunification plan.					