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| PARENT APPLICATION FOR ADOPTION MEDICAL SUBSIDY FOR AN ADOPTED CHILD | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Michigan Department of Health and Human Services (MDHHS) | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| **DIRECTIONS:** (Please TYPE or PRINT Clearly.)   * An adoption medical subsidy may be requested for physical, emotional, or mental conditions which existed or the cause of which existed prior to the adoption. * A child may be eligible for medical subsidy if:   •• The child is being adopted or was adopted from the Michigan public child welfare system.  •• The child is under age 18 at the time of the certification of the medical subsidy condition(s) by the MDHHS Adoption Subsidy Office.  •• The identified physical, mental or emotional condition or its cause existed before the Order Placing Child (PCA 320) was issued by the Court.   * Current (within the last 12 months) signed medical and/or professional documentation of diagnosed conditions, must be submitted with this application. * If the required documentation is not received with the application but is received **within** 90 calendar days of receipt of the application by the Adoption and Guardianship Assistance Office, **and** a medical subsidy is approved, the effective date of eligibility will be retroactive to the date the application was received. * If the required documentation is not received within 90 calendar days, the application will be denied. Reapplication can be made. * **To establish an adoption medical subsidy, parents must:**  1. Complete and submit this application to:   Michigan Department of Health and Human Services  Adoption and Guardianship Assistance Office, Ste. 612  PO Box 30037  Lansing, MI 48909 Telephone: 517-335-7801   1. Submit professional documentation identifying the condition and documenting that the condition or the cause of the condition existed prior to adoption. **Current documentation must be signed by the professional** (dated within the last 12 months) and must be attached to the application. **Physical/medical conditions must be diagnosed by a licensed physician. Mental health conditions must be diagnosed by a licensed psychologist, licensed psychiatrist, or fully licensed master social worker.** | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Adoption Medical Subsidy Coverage** (see AAM 640)  An adoption medical subsidy may provide payment for necessary treatment of conditions certified eligible under the Adoption Medical Subsidy Program. Services must be provided by a licensed and/or trained person or by a licensed facility. Parents are responsible for the selection of service providers, and obtaining any required preauthorizations.  **Most** services **MUST HAVE THE PRIOR APPROVAL** of the Adoption Services Specialist. Examples of services include, but not limited to: outpatient psychotherapy/counseling; transportation; physical care services; educational services, such as speech therapy, physical therapy, occupational therapy, tutoring, or education equipment/supplies; residential treatment or placement outside the family home; durable medical equipment, such as wheel chairs, ramps, etc.  **DO NOT ATTACH MEDICAL BILLS TO THIS APPLICATION.** | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| A. IDENTIFYING INFORMATION | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Child’s** Adoptive Name (Last, First, Middle Initial) | | | | | | | | | **Child’s** Birth Name (If known) (Last, First , Middle Initial) | | | | | | | | | | | | **Child’s** Date of Birth | | | | | | |
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| **Adoptive** Parent’s Name (Last, First, Middle Initial) | | | | | | | | | | | **Adoptive** Parent’s Name (Last, First, Middle Initial) | | | | | | | | | | | | | | | | |
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| **Adoptive** Parent’s Date of Birth | | | | | | | | | | | **Adoptive** Parent’s Date of Birth | | | | | | | | | | | | | | | | |
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| **Adoptive** Parent’s Email | | | | | | | | | | | **Adoptive** Parent’s Email | | | | | | | | | | | | | | | | |
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| Complete Address (Number and Street) | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| City | | | | | | | | | | | State | | | | Zip Code | | Telephone Number | | | | | | | | | | |
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| B. ELIGIBILITY INFORMATION | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 1. | Has the child previously been determined eligible for the Michigan Adoption Assistance Program and/or the Medical Subsidy Program? | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  |  | Yes, complete Sections C, D, E. | | | | | | | | | | | | | | | | | | | | | | | | | |
|  |  | No, complete B2, B3, C, D, E. | | | | | | | | | | | | | | | | | | | | | | | | | |
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| 2. | Was the child in the legal custody of the Michigan public child welfare system at the time the adoption petition was filed? | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  |  | Yes | |  | No | | | | | | | | | | | | | | | | | | | | | |  |
|  | Date of Adoption Finalization | | | | |  | | | | | |  | Not finalized | | | | | | | | | | | | | | |
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| 3. | Copies of the following documents must be submitted: | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | • Order of Adoption  • Birth Certificate  • Social Security Card | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| C. CONDITION(S) FOR WHICH A MEDICAL SUBSIDY IS BEING REQUESTED (Please see page 3 for specific documentation requirements.) | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | List specific physical, mental or emotional **conditions** for which a medical subsidy is being requested: | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 1) |  | | | | | | | | | | | 4) | |  | | | | | | | | | | | | | |
| 2) |  | | | | | | | | | | | 5) | |  | | | | | | | | | | | | | |
| 3) |  | | | | | | | | | | | 6) | |  | | | | | | | | | | | | | |
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| D. OTHER PAYMENT RESOURCES INFORMATION | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Has the child been determined eligible for any of the following resources? | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 1. Family Support Subsidy administered by Community Mental Health? | | | | | | | | | | | | | | | | | |  | Yes | | |  | No | | | | |
| 2. Children’s Special Health Care Services administered by Community Mental Health? | | | | | | | | | | | | | | | | | |  | Yes | | |  | No | | | | |
| 3. Medicaid program administered by the Michigan Department of Health and Human Services? | | | | | | | | | | | | | | | | | |  | Yes | | |  | No | | | | |
| 4. Private health insurance? | | | | | | | | | | | | | | | | | |  | Yes | | |  | No | | | | |
| 5. Supplemental Security Income (SSI)? | | | | | | | | | | | | | | | | | |  | Yes | | |  | No | | | | |
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| E. ACKNOWLEDGEMENT | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| I (we) understand the eligibility requirements for Adoption Medical Subsidy as described on this form.  I (we) understand if the child is found eligible for an Adoption Medical Subsidy, all available resources including private health insurance, Medicaid, Children’s Special Health Care Services, other available public monies and local or intermediate school district services, must be exhausted before requesting a Medical Subsidy payment to service providers, or to reimburse the family.  I (we) understand if the child is receiving Family Support Subsidy Payments through Community Mental Health, there is **no** eligibility for **payment** through the medical subsidy program.  I (we) understand the medical subsidy application must be received and eligibility approved by the Adoption and Guardianship Assistance Office **before** the child’s 18th birthday. | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| *Adoptive Parent’s Signature (required)* | | | | | | | | Date (required) | | *Adoptive Parent’s Signature (required if 2 parents)* | | | | | | | | | | | | | | Date (required) | | | |
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| The Michigan Department of Health and Human Services (MDHHS) does not discriminate against any individual or group because of race, religion, age, national origin, color, height, weight, marital status, genetic information, sex, sexual orientation, gender identity or expression, political beliefs or disability. | | | | | | | | | | AUTHORITY: P.A. 292 of 1980.  RESPONSE: Voluntary.  PENALTY: Form must be received by the Adoption Subsidy Office in order to be considered for a medical subsidy. | | | | | | | | | | | | | | | | | |

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| **SPECIFIC DOCUMENTATION REQUIRMENTS** |
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| All documentation (with the exception of medical birth records of prenatal drug exposure) must be signed by the appropriate diagnosing professional:   * **Physical conditions** must be documented by licensed physicians. * **Emotional conditions** such as anxiety disorder, adjustment disorder, oppositional defiant disorder, post-traumatic stress disorder, or attachment disorder must be documented by a licensed psychologist, limited licensed psychologist, psychiatrist, licensed master social worker, or physician. In cases where the diagnosing professional is not in Michigan, an equivalent state license is required. * **Psychiatric conditions** such as bipolar disorder or schizophrenia must be documented by a licensed psychiatrist, licensed psychologist, limited licensed psychologist, or licensed master social worker. * **Education/learning conditions** such as mental impairment, speech and language impairment, learning disability, developmental delay/disorder, emotional impairment, or autism must be documented by a current Individual Education Program (IEP) or Individual Family Service Plan (IFSP) document or a comprehensive evaluation by a psychologist or psychiatrist. * **Attention deficit disorder/attention deficit hyperactivity disorder** must be documented by either a licensed physician or by a fully licensed psychologist or psychiatrist. When the diagnosis is by a fully licensed psychologist, a comprehensive evaluation is required. * **Fetal alcohol spectrum disorder** must be documented by a medial geneticist, a licensed physician, or a licensed psychiatrist. * **Hearing loss** must be documented by an audiologist or licensed physician. * **Vision problems** must be documented by an optometrist, ophthalmologist, or licensed physician. * **Motor impairments** and sensory problems must be documented by an occupational therapist or licensed physician. * **Prenatal drug exposure** must be documented with lab reports or hospital records from the birth. * **Orthodontic problems** must be documented by an orthodontist or dentist.   **Note: The documentation must identify the condition and explain how the condition, or its cause, existed prior to the adoption. The Adoption and Guardianship Assistance Office will determine if the documentation submitted for any of the above conditions is sufficient to meet certification criteria for medical subsidy and may request additional documentation.** |