

CHILDREN'S ADMINISTRATION  
**Adoption Support Worksheet**

If more space is needed for your answers, please use the back of this form.

NAME OF CHILD	NAME OF ADOPTIVE PARENTS	DATE
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**Section 1. Child's Special Need and Related Expenses**

CHILD'S SPECIAL NEEDS AND RELATED EXPENSES	MONTHLY EXPENSE	AMOUNT PROVIDED BY PARENT	AMOUNT ASSISTANCE REQUESTED
	\$	\$	\$
	\$	\$	\$
	\$	\$	\$
	\$	\$	\$
	\$	\$	\$

**Section 2. Family and Community Resources**

Please list resources your family is currently accessing, or those services that are available, to offset the additional costs related to caring for the child. Examples are listed below.

SOURCE	AMOUNT
<input type="checkbox"/> Number of people supported by income: _____ Gross monthly income:	\$
<input type="checkbox"/> Supplemental Security Income (SSI), Social Security (SSA) / Veterans Benefits	\$
<input type="checkbox"/> Child Support (for other children in the home)	\$
<input type="checkbox"/> Working Connections Child Care Co-pay:	\$
<input type="checkbox"/> Other:	\$
<input type="checkbox"/> Family Medical Insurance List provider:	
<input type="checkbox"/> Developmental Disability Administration and/or Medicaid Personal Care	
<input type="checkbox"/> Birth to Three / Early Head Start / ECEAP / Developmental Preschool	

**Section 3. Average Expenses**

MONTHLY EXPENSES	AMOUNT	MONTHLY EXPENSES	AMOUNT
Housing	\$	Medical	\$
Utilities / phone	\$	Child Support	\$
Food	\$	Loans (not mortgage or rent)	\$
Car	\$	Credit card payments	\$
Insurance	\$	Dependent care	\$
Family Medical insurance	\$	Child care	\$
Educational expenses	\$	Other:	\$

**Section 4. Requested Benefits**

Can you adopt this child without the assistance of the adoption support program?  Yes  No

Monthly Cash Payment \$\_\_\_\_\_ (amount requested)  Counseling  Medical

Non-Recurring Costs \$\_\_\_\_\_ (amount listed on application)

ADOPTIVE PARENT'S SIGNATURE	DATE
ADOPTIVE PARENT'S SIGNATURE	DATE