|  |
| --- |
| **DEPARTMENT OF CHILDREN AND FAMILIES**Division of Safety and Permanence |

**SUBSIDIZED GUARDIANSHIP HIGH SCHOOL INFORMATION**

**Use of form:** This form is voluntary; however, the information requested must be provided in order to verify that Subsidized Guardianship benefits may continue after the child reaches 18 years of age. Personally identifiable information on this form is used to verify the information necessary for providing benefits and will be used only for this purpose.

**Instructions:** If additional space is needed, attach a separate sheet.

|  |  |
| --- | --- |
| Name – Child (Last, First, MI)      | Birthdate – Child (mm/dd/yyyy)      |
| Name – Parent 1 (Last, First, MI)      | Name – Parent 2 (Last, First, MI)      |
| Mailing Address – Parent(s) (Street, City, State, Zip Code)      |
| Daytime Telephone Number – Parent 1       | Daytime Telephone Number – Parent 2       |
| Check "Yes" or "No" for each item below. |
| 1. [ ]  Yes [ ]  No Child is in a full-time high school program. |
| 2. [ ]  Yes [ ]  No Child will be continuing in a full-time high school program past his / her 18th birthday. |
|  If "Yes", provide the following information. |
|  | Date – High School Graduation      | Name – High School      |
|  | **NOTE: Graduation date is needed to evaluate your child's eligibility for Subsidized Guardianship Assistance beyond age 18.** |
| 3. [ ]  Yes [ ]  No Child has entered military service. If "Yes", provide the enlistment date. | Date – Military Enlistment      |
| 4. [ ]  Yes [ ]  No Child is married. If "Yes", provide the date of marriage. | Date – Marriage      |
| 5. [ ]  Yes [ ]  No Is child living with you? If "No", provide the following information. |
|  | Date – Child Left Home      | Child's Current Living Arrangement (Check one)[ ]  Living independently [ ]  Foster Home [ ]  Residential Care Center for Children and Youth[ ]  Other – Specify:       |
|  | Address - Child (Street, City, State, Zip Code)      |
|  | Your Monthly Expenses for Child's Out-of-Home Care |
|  | Expense Type |  | Expense Amount |  | Expense Type |  | Expense Amount |
|  |       |  | $       |  |       |  | $       |
|  |       |  | $       |  |       |  | $       |
|  |       |  | $       |  |       |  | $       |
|  |       |  | $       |  |       |  | $       |
|  |  |  |  |  |
| 6. | Additional Information      |

DCF-F-CFS2371-E (R. 01/2015)

|  |
| --- |
| I hereby certify that the information that I have provided is true to the best of my knowledge.  |
| Name – Person Completing Form      | Relationship to Child      | Date – Form Completed      |
| **SIGNATURE** – Person Completing Form | Date – Form Signed      |

Thank you for keeping us informed of changes so we can provide your benefits promptly. If you have further questions, contact the Bureau of Permanence and Out-of-Home Care at 1-866-666-5532.

Return completed form to: Subsidized Guardianship

 DCF/DSP – Suite 101

 P.O. Box 8916

 Madison, WI 53708-8916

**FOR OFFICE USE ONLY** **[ ]** GRAD LTR [ ]  MA LTR

 2