**Subsidized Guardianship Request for Information to Determine Continued Eligibility**

**Use of Form:** This request for confirmation of continued eligibility is required pursuant to Wis. Stat. § 48.623(4) and Wis. Admin. Code § DCF 55.10(2)(a)-(c) to determine if the child and guardian(s) receiving subsidized guardianship payments remain eligible to continue receiving those payments. Personal information you provide may be used for secondary purposes [Privacy Law, s. 15.04(1)(m), Wisconsin Statutes].

This request for confirmation of continued eligibility is for:

[ ]  **An annual review:** This is the [ ]  **[ ] 1st notice** [ ]  **[ ] 2nd notice being sent.** This form must be returned to       on or before the annual review date       or the subsidized guardianship payment will be suspended until the form is returned.

[ ]  **A change in child or guardian(s)’s circumstances:** This form must be returned to      .

|  |  |
| --- | --- |
| Child’s Full Name      | Child’s Birthdate (mm/dd/yyyy)      |
| Guardian 1 Full Name      | Guardian 2 Full Name      |
| Address (Street, City, State, Zip Code)      |
| As a guardian receiving subsidized guardianship payments, you are responsible to notify the agency or department within 10 calendar days when there is a change in the circumstances listed below. Has any of the following occurred in the last year? If “Yes”, please provide the date of occurrence and requested supporting information. |
| **Yes** | **No** | **Change in Circumstance**  | **Date of****Change** | **Supporting Information Requested – Documentation by Guardian** |
| [ ]  | [ ]  | Has your address changed? |       | New Address (Street, City, State, Zip Code)      |
| [ ]  | [ ]  | Has there been a change in the child’s guardian? |       | New Guardian’s Name      |
|  |  |  |  | New Guardian’s Address (Street, City, State, Zip Code)      |
|  |  |  |  | New Guardian’s Telephone Number      |
|  |  |  |  | Name of circuit or tribal court that appointed new guardian.      |
| [ ]  | [ ]  | Has the child entered the military? |       |  |
| [ ]  | [ ]  | Has the child gotten married? |       |  |
| [ ]  | [ ]  | Has the child stopped living with you? |       |  |
| [ ]  | [ ]  | Does the child attend a full-time kindergarten to 12th grade educational program or its equivalent? |       |  |
| [ ]  | [ ]  | Have you stopped supporting the child? |       |  |
| [ ]  | [ ]  | Has your legal responsibility to the child ended? |       |  |
| [ ]  | [ ]  | Has a governmental agency or court placed the child outside your home? |       |  |
| [ ]  | [ ]  | Are the child’s parent(s) residing in your home? |       | If “Yes”, is the child’s parent(s) a minor or subject to an order for adult protective services or protective placement?[ ]  Yes [ ]  No |
| [ ]  | [ ]  | Has there been a change in the child’s commercial or private health insurance benefits? This may include gaining, changing, or losing coverage. If “Yes”, follow the instructions to the right for reporting this change. |       | If you currently reside in Wisconsin, contact ForwardHealth Member Services at 1-800-362-3002 to report a change in your child's health insurance benefits.If you currently reside outside of Wisconsin and your child receives Medicaid in the state in which you reside, contact that state's Medicaid program to report a change in your child's health insurance benefits. You may use this database to find a contact for your state's Medicaid program: <https://www.cms.gov/about-cms/contact/database>. Choose "State Medical Assistance Office" as the Organization Type and select the correct state. |
| [ ]  | [ ]  | Has the child died? |       |  |
| [ ]  | [ ]  | Would you like to name or change the individual listed as a prospective successor guardian on your subsidized guardianship agreement? |       | Prospective Successor Guardian(s)’s Name(s)      |
|  |  |  |  | Prospective Successor Guardian(s)’s Address (Street, City, State, Zip Code)      |
|  |  |  |  | Prospective Successor Guardian(s)’s Telephone Number      |
| [ ]  | [ ]  | Would you like to terminate the subsidized guardianship agreement for this child?  |       | If yes, please indicate the desired effective date of termination:       |
| Your subsidized guardianship agreement, which includes a monthly payment and the child’s Foster Care Medicaid coverage may continue until the month of the child’s high school graduation (or equivalent program) or when the child turns age 19, whichever comes first. You will receive a notice six months before the child’s 18th birthday regarding the child’s continued eligibility for subsidized guardianship after the age of 18.If the child or the guardian(s) is no longer eligible to receive subsidized guardianship payments due to a change in circumstance that affects eligibility listed above, the payments will be discontinued. The agency or department will provide notice of the suspension or termination of payments at least 30 days before the payments discontinue. |
| The information given above is true and complete to the best of my knowledge. |
|  |  |       |  |
| Guardian 1 Signature |  | Date Signed |  |
|  |  |       |  |
| Guardian 2 Signature |  | Date Signed |  |

**MAKE A COPY OF THIS FORM FOR YOUR PERSONAL RECORDS.**