**Kinship Care Review of Eligibility and Notice of Change of Circumstance**

**Use of form:** This form must be completed by the kinship caregiver and will be used by kinship care agency staff to determine continued eligibility at annual reassessment or whenever a change of circumstance has occurred. This request for confirmation of continued eligibility is required under s. 48.57, Wis. Stats. and Ch. DCF 58.10, Admin. Code to meet continued eligibility for kinship care payments. Personal information you provide may be used for secondary purposes [ s. 15.04(1)(m), Wis. Stats.].

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| Child’s Name (Last, First MI.) | | | | | | Kinship Care Provider Name | | |
| Kinship Care Provider Address(Street, City, State, Zip Code) | | | | | | | | |
| Kinship Care Provider Phone | | | | Kinship Care Provider Email | | | | |
| Have any of the following occurred **since your last kinship care review**? If “Yes”, please provide the date of the change and the requested supporting information if appropriate. | | | | | | | | |
|  | **Yes** | **No** | **Change in Circumstance** | | **Supporting Information Requested –**  **Documentation by Kinship Care Provider** | | | |
| 1a |  |  | Do you want to terminate the Kinship Care payment for this child? | | If “Yes”, enter the termination date:    Please explain why: | | | |
| 1b |  |  | Has the child’s parent(s) resided in your home for more than 30 days? | | If “Yes”, please explain the circumstances:    Is the parent a minor or receiving adult services?    Date they began living in the home: | | | |
| 1c |  |  | Does the child continue to reside with you? | | If “No”, please explain the circumstances:    Date they left your home: | | | |
| 1d |  |  | Has the child begun to receive supplemental security income due to their own disability (SSDI)? | | Date payments began: | | | |
| 1e |  |  | Has the child graduated, married, or entered the military? | | If “Yes”, please describe: | | | |
| 2a |  |  | Has **any** adult in your household had changes in their criminal history (new arrest, conviction or CPS assessment)? | | If “Yes”, please explain:    Adult’s name & relationship to child:    Description of the new child abuse findings, arrests, or convictions: | | | |
| 2b |  |  | Has your family’s address changed? | | If “Yes”, enter the new address (Street, City, State, Zip Code)    Date of the move: | | | |
| 2c |  |  | Have any new adults or minors moved into your home? | | If “Yes”, enter the name(s) of the new household members:    Date they moved in: | | | |
| 2d |  |  | Have any other changes occurred in your household (not mentioned above?) | | If “Yes”, please describe: | | | |
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| As the kinship care provider(s), you are responsible for notifying the agency or department, for the duration of kinship care, when there is a change in the circumstances listed above. This form may be used to notify the agency or department of a change in circumstance between annual reviews as required in s. 48.57, Wis. Stats. and Ch. DCF 58.10, Admin. Code.  This form must be returned to       prior to       or the kinship care payment may be terminated. Please contact       to schedule a home visit or if you have any questions regarding the completion of this form.  Please discuss any concerns you have regarding new arrests or convictions with your kinship care coordinator. The kinship care agency will make their eligibility determination based on several factors; details of the conviction, the child’s current safety, and whether the caregiver household continues to be in the child’s best interest. If there are changes in your kinship care eligibility, you have a right to an appeal and those rights and instructions will be included in your notice of payment termination.  If you are currently receiving Kinship Care payments and you submit a request for appeal within 10 days after the date of the notice, your payments will continue until an appeal decision is issued. Any payments issued while the appeal is pending may be recovered by the kinship agency if the agency’s determination is upheld*.* | | | | | | | | |
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| Kinship Caregiver Signature | | | | | | |  | Date |