**Notification of Kinship Care Termination**

**Use of form:** This form is used to notify Kinship Care relatives of their child’s termination of payments. Personally identifiable information on this form is used to verify the information necessary for providing benefits and will be used only for this purpose.

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Today’s Date | | | Case ID# | | | | |
| **CHILD’S INFORMATION** | | | | | | | |
| Name (Last, First, MI) | | | | | | Birthdate | 18th Birthdate |
| **RELATIVE CAREGIVER INFORMATION** | | | | | | | |
|  | Caregiver 1 | | | | | | |
|  | Name (Last, First, MI) | | | | Telephone Number (Home/Cell) | | |
|  | Email Address | | | | | | |
|  | Address (Street, City, State, Zip Code) | | | | | | |
|  | Caregiver 2 | | | | | | |
|  | Name (Last, First, MI) | | | | Telephone Number (Home/Cell) | | |
|  | Email Address | | | | | | |
|  | Address (Street, City, State, Zip Code) | | | | | | |
| **NOTICE** | | | | | | | |
| This notice is to inform you that the Kinship Care monthly payment may be terminated, effective       due to one or more of the following reason(s): | | | | | | | |
| The child is no longer in need of protection or services. [Ch. DCF 58.07] | | | | | | | |
| The relative caregiver has requested a termination of Kinship Care. [Ch. DCF 58.04 (1)] | | | | | | | |
| The relative caregiver is no longer eligible for Long-Term Kinship Care. [s. 48.57(3n)(am), Stats., and Ch. DCF 58.04] | | | | | | | |
| The relative caregiver, other adult resident, or an employee has a conviction that is a barrable offense for Kinship Care. [Ch. DCF 58.04 (5) and Ch. DCF 58.05 (6)] | | | | | | | |
| The relative caregiver/household is no longer in the best interest of the child. [Ch. DCF 58.08(4)]  Describe: | | | | | | | |
| The relative caregiver is receiving Foster Care or Subsidized Guardianship payment for the child. [Ch. DCF 58.04(3)] | | | | | | | |
| The child is receiving supplemental security income due to their own disability. [Ch. DCF 58.04(3)(b)] | | | | | | | |
| The child has turned 18 and the child is no longer a full-time student in a secondary school or its vocational or technical equivalent . [Ch. DCF 58.04(2)(h)] | | | | | | | |
| The child is:  No longer living with you. [Ch. DCF 58.04(4)]  Married. [Ch. DCF 58.10(1)(a)6.]  Entered the military. [Ch. DCF 58.10(1)(a)7.]  Deceased. [Ch. DCF 58.10(1)(a)8.] | | | | | | | |
| The child’s parent(s) moved into your home. (Ch. DCF 58.10(1)(a)(12) & (2)(b)] | | | | | | | |
| A determination has been made that the child is no longer receiving support from the caregiver, or is no longer living in your home. [Ch. DCF 58.10] | | | | | | | |
| The parent has rescinded their approval of the living arrangement (only for non-guardianship placements). [Ch. DCF 58.06)(6)(b)] | | | | | | | |
| The child has been removed from your home by a county agency, tribal agency or other governmental agency and placed into out-of-home care. [Ch. DCF 58.10(1)(a)(13)] | | | | | | | |
| The Kinship Care Relative did not cooperate with the agency’s requirements:  Annual review. [Ch. DCF 58.10(3)]  Foster Care Licensing (Court-ordered Kinship only). [Ch. DCF 58.04(1)(b)]  Other. Describe: | | | | | | | |
| Please contact       if you have any questions regarding the information shared in this form. | | | | | | | |
| **APPEALS PROCESS** | | | | | | | |
| **Request for Director Review** | | | | | | | |
| Name of Kinship Care Agency Director / Tribal Designee | | | | | | | |
| Mailing Address of Kinship Care Agency Director / Tribal Designee | | | | | | | |
| If Kinship Care payments are denied or terminated **based on a criminal background check**, you have a right to request a review by the director of the kinship care agency under s. 48.57, Stats. and Ch. DCF 58.11(1), Admin. Code.   * **The request must be in writing and must be received no later than 45 days after the date of this notice.** * The written request for review should be sent to the agency director or tribal designee. [Ch. DCF. 58.02(11)] * The request should include a short statement about the matter you are requesting a review of and the reason for your request. | | | | | | | |
| If you are currently receiving Kinship Care payments and you submit a request for review within 10 days after the date of the notice, your payments will continue until a review decision is issued. Any payments issued while the review is pending may be recovered by the kinship agency if the agency’s determination is upheld. | | | | | | | |
| **REQUEST FOR HEARING** | | | | | | | |
| You may have a right to request a hearing under s. 48.57, Stats. and Ch. DCF 58.11(2), Admin. Code.   * Your request for an appeal **must be sent** **directly to the Division of Hearings and Appeals** * Your request for an appeal **must be received no later than forty-five (45) days from the date of this notice.** * The request should include a short statement about the matter you are appealing and the reason for your appeal. * Please attach a copy of this notice to your request for a hearing. | | | | | | | |
| To submit your request for an administrative hearing under Ch. DCF 58.11(2), Admin. Code: | | | | | | | |
| ***Send your request via U.S. Mail:***  Division of Hearings and Appeals  P.O. Box 7875  Madison, WI 53707-7875 | | ***Hand-deliver your request:***  Division of Hearings and Appeals  4822 Madison Yards Way  Madison, WI 53705 | | ***Send your request via Facsimile:***  Division of Hearings and Appeals  (608) 264-9885 | | | |
| If you are currently receiving Kinship Care payments and you submit a request for a hearing within 10 days after the date of the notice your payments will continue until a hearing decision is issued. Any payments issued while the hearing is pending may be recovered by the kinship agency if the agency’s determination is upheld. | | | | | | | |