

KINSHIP ASSISTANCE APPLICATION .

SACWIS Case Name: _____ Today's date _____

Home study approval date _____ Placement or custody date _____

Applicant information:

Caregiver Name _____ DOB: _____ Social Security # _____

Caregiver Name _____ DOB: _____ Social Security # _____

Home address _____ City, Zip _____

Home phone _____ Cell phone _____ E-mail _____

Caregiver employment:

Place of Employment _____ Title _____

Place of Employment _____ Title _____

Other adults in the home(18 years +):

Name _____ DOB _____ SS# _____

Relationship to caregiver? _____ Dependent of caretaker? _____

Name _____ DOB _____ SS# _____

Relationship to caregiver? _____ Dependent of caretaker? _____

All children in the home(0-18 years):

Name _____ DOB _____ S. S. # _____

Relationship to caregiver _____ Kinship placement? _____ Placement date _____

Name _____ DOB _____ S. S. # _____

Relationship to caregiver _____ Kinship placement? _____ Placement date _____

Name _____ DOB _____ S. S. # _____

Relationship to caregiver _____ Kinship placement? _____ Placement date _____

HAVE YOU BEEN TO DEPT. OF JOBS & FAMILY SERVICES TO APPLY FOR AID?

Ohio Works First "Child Only" Benefits? Yes _____ No _____ Outcome? _____

Food Stamps? Yes _____ No? _____ Outcome? _____

Is the child eligible for WIC: Yes _____ No _____ Application made or coupons transferred? _____

Does the kinship provider hold temporary custody or does WCCSB? _____

Applying for foster/adopt license? _____ Date of application _____

KINSHIP ASSISTANCE APPLICATION .

Instructions for Kinship or Ongoing Caseworker:

1. Kinship Assistance Application is intended to meet the transitional expenses of a child that has been in the custody of the agency and is now being moved into the home of a relative/kinship caregiver. This application may be submitted the **first three (3) months of child placement and/or temporary custody to the relative.**
2. Applicants must have a staffed and approved home study prior to application. (Applications may also be made for children making transitional pre-placement visits, once home study and placement change is approved.)
3. Up to \$600.00 (per child in placement) is available for assistance with items the child/family needs to help support the **transition** of the child into the kinship home....**OR** \$200.00 per child/month (for 3 months) cash stipend is available if no items are requested.
4. Items and services typically requested that may be included on the application:
 - beds, dressers, bed linens, mattress protectors
 - infant and baby equipment, strollers, high chairs, etc.
 - clothing (school, replacement, initial, seasonal changes, special occasion)
 - school supplies, fees, or school pictures
 - groceries that will support the initial placement
 - social recreational or extracurricular activities for the children
 - other **needs** that can support the transition of these children to this home.
 (Gift cards/stores are at the discretion of the agency due to financial billing/bookkeeping.)

Please write a brief summary of current family need:

Item(s)	To be acquired at:	Child(ren)	Cost(may use "up to:")

PLEASE NOTE: Large items such as beds and dressers, cars seats, cribs, etc. purchased for child's use will follow the child in placement **or be returned to Wayne County Children's Services at termination of placement.**

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Applicant please read:

I, _____ have discussed the items listed with the Kinship or Ongoing Caseworker and understand that the items purchased are to match the items listed on the application. I also agree to return to the agency receipts for the purchases made using the gift cards within 30 days of receipt of funds/gift cards. Large items purchased (with these funds) for children placed in my home will be returned to the agency or follow the children if the children should move out of my home.

***Receipts of all items purchased will be turned into caseworker for agency bookkeeping.**

Applicant Printed Name _____ Date _____

Applicant signature _____ Date _____

Caseworker signature _____ Date _____

Supervisor signature _____ Date _____

PCSA Representative:

Approval _____ Date _____ Signature _____

Denial _____ Date _____ Signature _____

If denial, explanation: _____

Checks to be mailed to:

Kinship Provider _____ Monthly check \$ _____ or \$100 X _____

Address: _____

Please note: This program is no longer state mandated and is at the discretion of WCCSB.

APPLICATION ROUTING:

1. Kinship or Ongoing Caseworker will give completed applications to their immediate supervisor for approval and signature.
2. Unit Supervisor will submit completed application to Clinical Director or Social Service Administrator.
3. Financial Director will have the final approval and advise direct caseworker when and where gift cards have been ordered and/or when the first check will be mailed to applicant.

***Because this is to care for the **transitional** needs of a child being placed, processing time for the approval of the submitted application is requested to take 3 business days so that the caregiver is not spending funds for things on this application out of necessity.