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| **INSTRUCTIONS Modification of GAP Agreement** |
| This worksheet is designed to assist you in requesting a modification to the GAP monthly cash subsidy.  GAP monthly cash payments may be automatically adjusted if the State makes an across-the-board reduction in foster care maintenance rates. Additionally, the guardian or DCYF may propose adjustments in monthly cash payments in writing at any time based upon:   * An increase or decrease in the special needs of the child or youth. * A change in circumstances of the guardianship family, or * A change in the maximum allowable monthly cash payment based on the age of the child or youth.   When requesting an adjustment in the monthly cash payment, the guardian(s) must provide documentation of any changes to the child’s or youth’s special needs, and or the family circumstances. The monthly cash GAP subsidy payment cannot exceed the foster care maintenance amount that the child or youth would receive if the child were placed in a foster family home. |
| **Please complete a worksheet for EACH CHILD OR YOUTH you are applying for. Please list your child or youth’s name, your name, and the date.** |
| **SECTION 1 –Reason for Modification**  Please check the box for each reason you are requesting a modification of the GAP agreement. Provide additional comments in the ‘describe’ box.  Do not complete this document for the Extended Guardianship Assistance Program (EGAP). Complete the EGAP Application DCYF 07-017 |
| **SECTION 2 – Family and Community Resources**  Please list the resources that your family is currently accessing. These resources may include financial support or service supports.   * Use “Other” to identify any resources not listed. |
| **Section 3 Family Circumstances**  Please enter the following:   * The number of children or youth for whom you will become a legal guardian. * Number of family dependents * Do include adult (elderly) dependents living in your home for home you are financially responsible. * Your current monthly family income. * Please enter the information regarding your family estimated monthly expenses and any out of the ordinary expenses. |
| **Section 4 Determining Foster Care Maintenance Level**  As of January 1, 2024, DCYF changed its method when determining the foster care maintenance level for a child or youth. We will need your assistance with providing information and documentation for the youth the modification is requested. Documentation will be requested to finalize the level. |
| **Section 5 – Signature(s) of applicant -** Please sign and date the form. |
| **Section 6– Negotiated Agreement (To be completed by GAP Gatekeeper).** |

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|  | **Request for Modification of Current Guardianship Assistance Program (GAP) Subsidy Worksheet** | | | | |
| **Type:**  GAP | | | | | |
| NAME OF CHILD OR YOUTH | | NAMES OF GUARDIANS | | | DATE OF REQUEST |
| **Section 1 - Reason for modification:** | | | | | |
| **Check all that apply:**  An increase or decrease in the special needs of the child or youth,  A change in circumstances of the guardianship family, or  A change in the maximum allowable monthly cash payment based on the age of the child or youth. | | | | | |
| **Section 2 – Family and Community Resources** | | | | | |
| Please list resources your family is currently accessing, or those services that are available, to offset the additional costs related to caring for the child or youth. Examples are listed below. | | | | | |
| SOURCE | | | | | AMOUNT |
| Number of people supported by income: ;  Gross monthly income: | | | | | **$** |
| Supplemental Security Income (SSI), Social Security (SSA) / Veterans Benefits | | | | | **$** |
| Child Support (for other children or youth in the home) | | | | | **$** |
| Working Connections Childcare co-pay | | | | | **$** |
| Other: | | | | | **$** |
| Family Medical Insurance; List provider: | | | | | |
| Developmental Disabilities Administration and/or Medicaid Personal Care | | | | | |
| Birth to Three / Early Head Start / ECEAP / Developmental Preschool | | | | | |
| **Section 3- Family Circumstances** | | | | | |
| TOTAL NUMBER OF CHILDREN OR YOUTH GUARDIAN OF: | | | TOTAL NUMBER OF YOUR DEPENDENTS IN HOUSEHOLD | | |
| FAMILY’S AVERAGE EXPENSES | | | | | |
| MONTHLY EXPENSES | AMOUNT | | MONTHLY EXPENSES | | AMOUNT |
| Housing | **$** | | Medical | | **$** |
| Utilities / phone | **$** | | Child Support | | **$** |
| Food | **$** | | Loans (not mortgage or rent) | | **$** |
| Car | **$** | | Credit card payments | | **$** |
| Insurance | **$** | | Dependent care | | **$** |
| Family Medical Insurance | **$** | | Child care | | **$** |
| Educations expenses | **$** | | Other: | | **$** |
| **Section 4– Determining Foster Care Maintenance Level** | | | | | |
| **As of January 1, 2024, DCYF changed its method when determining the foster care maintenance level for a child or youth. Please check any that may apply for the youth in this modification request. Documentation is necessary. Provide brief description in each section you answered yes.** | | | | | |
| **Age of child** | | | | **Chronic Physical health Continued** | |
| Yes  No  Is the youth 12 and older? | | | | Yes  No  Atrial Septal effect | |
| **Acute Mental Health** | | | | Yes  No  Other Describe | |
| Yes  No  Suicide attempts or self-harm | | | | Describe is selected yes to any above: | |
| Yes  No  Crisis mental health services | | | | **Mental Health Prescription** | |
| Yes  No  Inpatient MH hospitalization | | | | Yes  No  Psychotropic | |
| Yes  No  Polypharmacy | | | | Yes  No  Anti-Anxiety | |
| Yes  No  Antipsychotic or antimanic medications | | | | Yes  No  Antidepressants | |
| Describe is selected yes to any above: | | | | Yes  No  ADHD medications | |
| **Chronic Physical Health** | | | | Describe is selected yes to any above: | |
| Yes  No  Diabetes type 1 | | | | **Developmental Disability** | |
| Yes  No  Diabetes type 2 | | | | Yes  No  Autism or other pervasive learning disability | |
| Yes  No  Severe asthma | | | | Yes  No  Motor or Tic (down syndrome) | |
| Yes  No  Gastrostomy tube | | | | Yes  No  DDA services | |
| Yes  No  Dialysis | | | | Mental Health Diagnosis | |
| Yes  No  CFS Shunt | | | | Yes  No  Psychotic | |
| Yes  No  Organ Transplant | | | | Yes  No  Bi-Polar/Mania | |
| Yes  No  Leukemia | | | | Yes  No  Depression | |
| Yes  No  Tracheostomy/ventilator | | | | Yes  No  Anxiety | |
| Yes  No  Muscular Dystrophy | | | | Yes  No  ADHD | |
| Yes  No  Cystic fibrosis | | | | Yes  No  Impulse control disorders (ODD, Conduct, Antisocial) | |
| Yes  No  Paraplegia | | | | Yes  No  Trauma For Trauma to be checked there will need to be a DSM trauma diagnosis. | |
| Yes  No  Quadriplegia | | | | **Other factors** | |
| Yes  No  Lymphoma | | | | Yes  No  Y determined/adjudicated SOY/Supervision plan | |
| Yes  No  Leukemia | | | | Yes  No  Substance Use/disorder | |
| Yes  No  Brain tumor | | | | Yes  No Running away behavior | |
| Yes  No  Cancer | | | | Yes  No  Other Describe | |
| Yes  No  Chronic Pulmonary Conditions | | | | Describe is selected yes to any above: | |
| **Section 5 – Signature(s) of applicant** | | | | | |
| GUARDIAN’S SIGNATURE DATE | | | | | |
| GUARDIAN’S SIGNATURE DATE | | | | | |
| **Section 7 – Negotiated Agreement (To be completed by GAP Gatekeeper)** | | | | | |
| NEGOTIATED MONTHLY PAYMENT | | | | | |
| DECISION NOTES | | | | | |