Connecticut Department of Children and Families
SUBSIDIZED GUARDIANSHIP APPROVAL CHECKLIST
DCF-2051G
10/19 (Rev.)

DCF SW LAST Name:	DCF SW FIRST Name:	DCF Office: Select DCF Office		
Child LAST Name	Child FIRST Name	Child's DOB:	Child's SS #:	Date:
Medical #:	State of Residence:	Is Child DDS Eligible?: ☐ Yes ☐ No	Does Child Receive Medicaid From Out-of-State? ☐ Yes ☐ No	

CHECK BELOW FOR TYPE OF SUBSIDY:

Please enter the Per Diem Rate, based upon the box checked on the left: _____

- ☐ Basic Financial and Medical
- ☐ Medical Only
- ☐ Medically Complex - packet must include DCF-2101 signed by RRG and treating physician within the previous six months. The child's doctor must check the box that child is certified as medically complex.
- ☐ Therapeutic/Professional - Packet must include letter stating per diem rate and need for continued rate and family's home study. Per diem rate set by therapeutic/professional foster care agency:
- ☐ Other - any guardianship subsidy rate higher than a basic rate or when a child is not in a TFC-approved home, must include Office Director's or Assistant Bureau Chief signed approval memo with per diem rate.
- ☐ Exceptional Expense Subsidy: _____
- ☐ IV-E: Is this child IV-E eligible? ☐ Yes ☐ No
- ☐ Related Siblings: Is this child related only to a sibling in the provider's home and not to the provider? ☐ Yes ☐ No

PACKET MUST BE SIGNED BY PROPOSED GUARDIAN AND DCF STAFF WHERE APPLICABLE AND INCLUDE:

- ☐ Copy of Birth Certificate
- ☐ Copy of Social Security Card
- ☐ DCF-2101, Medically Complex Certification form signed and checked as certified by child's physician (if applicable)
- ☐ DCF-2158, Assessment of Child and Family for Subsidized Guardianship
- ☐ DCF-2159, Application for Guardianship Subsidy (including approved Exceptional Expense Subsidy)
- ☐ DCF-418-I-G, Initial Agreement for a Guardianship Subsidy
- ☐ DCF-552-G,Title IV-E Guardianship Subsidy Application
- ☐ JD-JM-31, Order of Termination of Parental Rights
- ☐ JD-JM-58, Order of Temporary Custody
- ☐ JD-JM-65, Adjudicatory/Dispositional Orders
- ☐ MA-1 Medical Assistance Form
- ☐ REU emails from Revenue Enhancement regarding IV-E status and Social Security benefits status prior to Transfer of Guardianship

Date child was placed in foster Care:	Date child placed by DCF with Guardian:	*Note: In order to be eligible for a DCF financial or medical subsidy, the child must be currently in the care of the proposed guardian and have been in licensed or approved foster care for at least six months before the TOG may occur in SCJM.*

PROPOSED GUARDIAN INFORMATION:

LINK Provider #:	Parent #1 LAST Name:	Parent #1 FIRST Name:	Parent #2 LAST Name:	Parent #2 FIRST Name:

☐ Licensing worker has verified that all licensing and background checks are in the provider fine.

OUT-OF-STATE PROPOSED GUARDIAN INFORMATION:

Out-of-state guardians must have a current license or approval from the state in which they reside that is in effect on the date of the Transfer of Guardianship in SCJM.	License Date:	License Expiration Date:

Copies in Packet: (*Note: Some states may not provide copies of actual background checks but will send a letter to confirm that background checks were completed and that the family was approved or licensed)*

- ☐ Approved DCF-100-A
- ☐ Copy of proposed guardian's approved home study
- ☐ Copies of background checks for any person age 16 and over in proposed guardian's household.

Reviewed by (Name of DCF Social Work Supervisor):	Signature of DCF Social Work Supervisor:	Date:
Reviewed by (Name of Subsidy Permanency Specialist CSC):	Signature of Subsidy Permanency Specialist CSC:	Date:
Approved by (Name of Subsidy Unit Program Supervisor):	Signature of Subsidy Unit Program Supervisor:	Date: