Connecticut Department of Children and Families

APPLICATION FOR GUARDIANSHIP SUBSIDY

DCF-2159
10/19 (Rev.)

PROPOSED GUARDIAN #1		PROPOSED GUARDIAN #2	
LAST Name	FIRST Name	LAST Name	FIRST Name
E-mail:	Phone #:	E-mail:	Phone #:
Relationship to Child:		Relationship to Child:	

Address (No. and Street):	Apartment #:	City:	State:	Zip:

CHILD

Child LAST Name	Child FIRST Name	DOB:	Gender:

Address (No. and Street):	Apartment #:	City:	State:	Zip:

Date of Commitment to DCF	Date of Placement with Proposed Guardian:	Current Per Diem Rate:

Type of Subsidy Requested: (Check all that apply)

☐ Per Diem financial subsidy ______________________

☐ Medical subsidy – provided by DSS Husky Program (for CT residents only)

☐ Exceptional expense – requires prior written approval by Subsidy Program Supervisor:

MEDICAL SUBSIDY: Does the child have private medical insurance through a parent or the proposed guardian? ☐ Yes ☐ No

EXCEPTIONAL EXPENSE SUBSIDY: Amount Requested: (Maximum of $2000)

Explain the nature of the expense and how it relates to the assumption of guardianship, when it was incurred, and other resources for payment which have been explored. **Attach receipts or documentation of the expense** and **written approval by Central Office Subsidy Supervisor:**

IMPORTANT LEGAL NOTICE

An applicant for, or recipient of, a guardianship subsidy from the Department of Children and Families has the right to appeal any denial, adjustment or termination of a subsidy at a DCF Administrative Hearing. At that hearing, the applicant, or the recipient, has the right to be represented by any person the applicant or recipient selects, at the applicant's or recipient's expense. You may request a hearing by writing to the DCF Administrative Hearings Unit, 505 Hudson Street, Hartford, CT 06106.

SIGNATURES (Note: Must be signed by all parties **PRIOR** to the Transfer of Guardianship in Superior Court for Juvenile Matters.)

I / We have received a copy of the Regulations of Connecticut State Agencies and DCF Policy regarding the Subsidized Guardianship Program.

I / We certify that the terms of this application are true and accurate to the best of my knowledge and belief.

Proposed Guardian #1 LAST Name:	Proposed Guardian #1 FIRST Name:	Proposed Guardian #1 Signature:	Date:
Proposed Guardian #2 LAST Name:	Proposed Guardian #2 FIRST Name:	Proposed Guardian #2 Signature:	Date:

DCF CERTIFICATION OF THE SUBSIDY:

☐ A monthly financial subsidy in the amount of ___________________________, per diem, has been negotiated with the proposed guardian(s).

☐ The child is eligible for a medical subsidy.

☐ An exceptional expense subsidy is authorized for the amount of: ____________________________

Submitted by, SW LAST Name:	SW FIRST Name:	Social Worker Signature:	Date:
Approved by, SWS LAST Name:	SWS FIRST Name:	Social Work Supervisor Signature:	Date:
Approved by, PS LAST Name:	PS FIRST Name:	Program Supervisor Signature:	Date:
Approved by OD LAST Name:	OD FIRST Name:	Office Director Signature:	Date:
Subsidy PS LAST Name:	Subsidy PS FIRST Name:	Subsidy Program Supervisor Signature:	Date:

The Department of Children and Families does NOT agree to the following subsidy(ies) as requested by the applicant:

☐ Monthly

☐ Medical

☐ Exceptional Expense

Denied by, PS LAST Name:	PS FIRST Name:	Program Supervisor Signature:	Date: