MDHHS-6006, YOUNG ADULT ADOPTION AND GUARDIANSHIP ASSISTANCE VERIFICATION OF ELIGIBILITY

Michigan Department of Health and Human Services (MDHHS)
Adoption and Guardianship Assistance Office (AGAO)
(New 6-22)

Youth Name | Caseworker Name

SECTION 1 – INSTRUCTIONS

To be completed by an employer, school personnel, or medical professional with knowledge of the above-referenced youth's participation with your business/organization. Please complete the appropriate section and provide your information/signature on the second page.

This form is used to document initial and ongoing program eligibility but is not required if other documents are being submitted that verify eligibility, such as pay stubs. This form can be used to document one type of eligibility. If the youth is required to show two types, such as both education and employment, then a MDHHS-6006 needs to be completed for each.

SECTION 2 – EMPLOYMENT

Employer, please provide the information requested in the section below for the above-named employee.

You hereby authorize to release the information requested below to MDHHS.

Employee Name | Employee Signature

Employer Name | Occupation

Date Employment Began | Date of First Paycheck

Number of Hours Expected to work ☐ Per Week or ☐ Per Pay Period

If already working, enter the number of hours completed in the last three calendar months

Month	Total Hours	Month	Total Hours	Month	Total Hours

Is the employee expected to work at least 80 hours per month? ☐ Yes ☐ No

SECTION 3 – HIGH SCHOOL/GED COMPLETION EDUCATION

School official, please provide the information requested below for the above-named student.

You hereby authorize to release the information requested below to MDHHS.

Student Name | Student Signature

Name of School | Type of School ☐ High School ☐ GED Preparation

Is the student actively working toward a diploma or GED? ☐ Yes ☐ No

Date Started to Attend | Attendance End Date | Expected Date of Graduation

SECTION 4 – COLLEGE/VOCATIONAL TRADE OR TECHNICAL TRAINING

School official, please provide the information requested below for the above-named student.

You hereby authorize to release the information requested below to MDHHS.

Student Name | Student Signature

Name of School

Type of School | Enrollment Date | Expected Graduation Date

☐ College ☐ Vocational Trade or Technical Training

Enrollment Status

☐ Full-Time Student ☐ Half-Time Student ☐ Less than Half-Time ☐ Not Enrolled

SECTION 5 – MEDICAL NEEDS

Medical professional, please provide the information requested below for the above-named patient.

You hereby authorize to release the information requested below to MDHHS.

Patient or Representative's Name | Patient or Representative's Signature

Diagnosis(es)

Date of Diagnosis(es) | Is the patient unable to work, volunteer, or attend school at least part-time?

☐ Yes ☐ No

How long is this condition expected to last? | When can the patient return to work?

SECTION 6 – SIGNATURE/CONTACT INFORMATION FOR OFFICIAL COMPLETING FORM

Business/Organization/School/Medical Practice Name

Name | Title | Phone Number

Address | City | State | Zip Code

Signature | Date

The Michigan Department of Health and Human Services will not exclude from participation in, deny benefits of, or discriminate against any individual or group because of race, sex, religion, age, national origin, color, height, weight, marital status, partisan considerations, or a disability or genetic information that is unrelated to the person's eligibility.