QUARTERLY YOUNG ADULT EXTENSION REVIEW

Young Adult Subsidy Extension Programs

Michigan Department of Human Services

Payee's Name and Address	Young Adult's Name
	Date of Birth
	Parent/Guardian Phone Number ( )
	Youth's Phone Number ( )

DEAR PARENT/GUARDIAN:

Please complete the enclosed three-Month Review Report and return it to the subsidy office within 30 calendar days. IF THE FORM IS NOT RETURNED, THE DEPARTMENT MAY END YOUR SUPPORT SUBSIDY.

EACH SECTION ON THE FORM MUST BE COMPLETED

Note: *All of the information is about the adoptive family/guardian, not the youth's birth family.*

Section 1. This section is to provide information about the youth's current status, living arrangements and participation in education/employment activities. Check the appropriate box or boxes. **At least one box must be checked.**

Section 2. This section is to provide current information about the youth's medical coverage. Check the appropriate box or boxes.

- If the youth has no private medical coverage, check the box, "NO PRIVATE INSURANCE COVERAGE FOR YOUTH."
- Do not check insurance coverage that you carry **only** for yourself.

Section 3. This section is to provide current information about money being received for the youth from Retirement Survivors Disability Insurance (RSDI), Veteran's benefits (VA), etc., other than subsidy payments.

- If your youth is not receiving benefits other than adoption subsidy, check the first box.
- Do not include the amount you receive from the Adoption Subsidy program.
- If your youth receives RSDI benefits, please enclose a copy of the most current *Notice of Award or claim letter* from the Social Security Administration (SSA). Please indicate if benefits come from the birth or adoptive parent(s). To obtain a claim letter, contact your local Social Security Administration either in person or by phone at the number listed in your phone book. You may also call the toll free number listed.
- If you do not have the above documentation, a printout of benefits can be obtained by calling or visiting your local Social Security Office. You may send a copy of the benefit letter to us later.

Section 4. This section indicates if the adoptive parent/guardian would like payment to continue if eligible.

Section 5. **Adoptive Parent(s)/Guardian(s) Signature**: Each parent/guardian must sign and date the form. If divorced, only one parent/guardian must sign.

Youth's Signature is required.

Please complete and return this form with original signatures to:

Department of Human Services
DHS Subsidy Office
235 S. Grand Ave., Suite 612
PO Box 30037
Lansing, MI 48909

AUTHORITY: MCLA 400.115i COMPLETION: Mandatory. PENALTY: Failure to comply may result in further investigation.	Department of Human Services (DHS) will not discriminate against any individual or group because of race, religion, age, national origin, color, height, weight, marital status, sex, sexual orientation, gender identity or expression, political beliefs or disability. If you need help with reading, writing, hearing, etc., under the Americans with Disabilities Act, you are invited to make your needs known to a DHS office in your area.

1. STATUS OF THE YOUNG ADULT (Check only the boxes which currently apply)

- ☐ Enrolled in school (including home school programs) (attach DHS-3380, Verification of Student Information) School Name: _____
- ☐ Not in school.
- ☐ Is enrolled in a college, university, vocational or trade school (attach DHS-3380, Verification of Student Information)
- ☐ Participating in a program or activity to promote employment or remove barriers to employment (attach DHS-3380, Verification of Student Information)
- ☐ Is employed at least 80 hours per month in either full-time, part-time (attach DHS-38, Verification of Employment)
- ☐ Is incapable of doing any of the above educational or employment activities due to a medical condition (either short-term or long-term). (Attach DHS-54A, Medical Needs)
- ☐ Youth's living arrangements have changed. Youth residing with: _____ . Youth's current address: _____ .
- ☐ Date guardianship ended, if applicable.
- ☐ Date married, _____ .
- ☐ Date entered military service, _____ .
- ☐ Date initial SSI payment, _____ .
- ☐ Is no longer receiving any support from me (Please provide written explanation)
- ☐ Youth is incarcerated. Date: _____ .
- ☐ Date of death, _____ .
- ☐ Other _____ .

2. HEALTH COVERAGE VERIFICATION

- ☐ PRIVATE INSURANCE
  Name of Private Insurance _____
  Private Insurance Coverage ☐ Major Medical ☐ Dental ☐ Vision ☐ Catastrophic Only
- ☐ NO PRIVATE INSURANCE FOR YOUTH
- ☐ MEDICAID
- ☐ OTHER RESOURCE

3. OTHER PAYMENT RESOURCES

	Current Amount	Date Current Benefits Began
☐ No other benefits being received for child.	$	
☐ Retirement Survivor Disability Insurance	$	
☐ Veteran's benefits	$	
☐ Family Support subsidy from Department of Community Health	$	
☐ Other	$	

4. REQUESTING SUBSIDY

We are requesting subsidy for above named youth to be:

☐ Continued ☐ Discontinued

6.→ PLEASE BE SURE ALL ITEMS ARE COMPLETED BEFORE SIGNING. AT LEAST ONE BOX MUST BE CHECKED IN EACH SECTION. I DECLARE THAT THE STATEMENTS ABOVE ARE TRUE TO THE BEST OF MY INFORMATION, KNOWLEDGE AND BELIEF. ←

Parent's/Guardian's Signature:	Date
Parent's/Guardian's Signature:	
Young Adult's Signature:	Date

DHS Worker Signature:	