



# APPLICATION FOR NONRELATIVE CAREGIVER FINANCIAL ASSISTANCE

## SECTION I. IDENTIFYING INFORMATION

Nonrelative Caregiver Name: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

City: \_\_\_\_\_ State: FL Zip: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Email Address: \_\_\_\_\_ Phone Number: \_\_\_\_\_

## SECTION II. SIGNATURE/ ATTESTATION – APPLICANT/ NONRELATIVE CAREGIVER

I, \_\_\_\_\_, nonrelative caregiver for (child) \_\_\_\_\_ request nonrelative caregiver financial assistance to help me care for the dependent child. Without the financial assistance, I am not able to continue to care for the child long term. I understand the nonrelative caregiver financial assistance payments are provided on a first come, first served basis, until funding is no longer available. If all funding is used, I understand the nonrelative caregiver payments will be suspended. I also understand if approved for nonrelative caregiver payments, my case may be subject to an annual eligibility review.

Signature of Nonrelative Caregiver: \_\_\_\_\_ Date: \_\_\_\_\_

## SECTION III. DEPENDENT CHILD (To be completed by the child welfare professional at initial application or the nonrelative caregiver at annual eligibility reassessment)

Child's Name: \_\_\_\_\_ Child's Date of Birth: \_\_\_\_\_

Does the child receive SSI?  YES  NO (If yes, ineligible for program)

Does the child receive SSDI or SSA survivor benefits?  YES  NO

If yes, how much does the child receive on a monthly basis? \_\_\_\_\_

Is the child still living in your home?  YES  NO If no, date child last lived in the home \_\_\_\_\_

Has the child been adopted by you?  YES  NO If yes, date child was adopted \_\_\_\_\_

Is the Nonrelative Caregiver a licensed foster home?  YES  NO If yes, date licensed \_\_\_\_\_

Does a related half-sibling of this child live in your home?  YES  NO

If yes, do you receive a Relative Caregiver Program payment for the half-sibling placed in your home?  YES

NO Child's Name: \_\_\_\_\_ DOB: \_\_\_\_\_

## SECTION IV. PLACEMENT INFORMATION (To be completed at initial application by the child welfare professional)

Child's FSFN ID: \_\_\_\_\_ Provider ID: \_\_\_\_\_

Date Unified Home Study (UHS) was completed in FSFN: \_\_\_\_\_

Date court order adjudicating the child dependent: \_\_\_\_\_

Date of court order placing the child in care and custody of the nonrelative caregiver: \_\_\_\_\_

## SECTION V. SIGNATURE – CHILD WELFARE PROFESSIONAL (To be completed at initial application by the child welfare professional)

I, \_\_\_\_\_, the child welfare professional for the dependent child, (child's name) \_\_\_\_\_, certify that all requirements in Section III and Section IV have been met. I further certify that all FSFN person and provider records have been updated and are complete. The dependent child is under the age of 18 and he or she was placed by the court in the care and custody of the nonrelative caregiver: \_\_\_\_\_

Date all requirements in Section III and Section IV were met: \_\_\_\_\_

Signature of Child Welfare Professional: \_\_\_\_\_ Date Signed: \_\_\_\_\_

Date Application Submitted to Department of Children and Families: \_\_\_\_\_