

## REASSESSMENT INFORMATION - ADOPTION ASSISTANCE PROGRAM

CHILD'S NAME
CHILD'S DATE OF BIRTH
CHILD'S AAP BENEFIT CASE NUMBER
COUNTY

DUE DATE (14 DAYS AFTER DATE MAILED)

The purpose of this form is to provide the adoption agency with an update of the needs of the child for whom you are receiving an Adoption Assistance Program (AAP) benefit and Medi-Cal coverage. Failure to complete and return this form within two weeks (14) days of the date it was mailed may cause interruption or delay in your receipt of the benefit. If this form is not returned to the adoption agency by the date it is due, the agency will conclude that an AAP benefit is no longer required and the AAP benefit and Medi-Cal coverage may stop. Please complete, sign and date this form within two weeks, attaching extra sheets if necessary, and send it to:

NAME OF ADOPTION AGENCY	COUNTY OF SANTA CLARA
ADDRESS	Social Services Agency 333 W. Julian Street San Jose, California 95110-2335
TELEPHONE	( 408 ) -975-5119

**Check (✓) one of the following:**

- We are legally responsible for the support of the child, and we are supporting the child.
- We are no longer legally responsible for the support of the child.
- We are no longer supporting the child.

**Check (✓) one of the following**

1. I/We no longer wish to receive an AAP benefit and/or Medi-Cal coverage for the above-named child. If the child's need change, I/we may contact the agency at that time.
2. I/We continue to need an AAP benefit and/or Medi-Cal coverage for the above named child. The needs of the child have not changed to warrant a reduced level of payment, nor has there been any change in the child's income. I/We request that the AAP benefit continue at the current level. I/We understand that my/our child's next reassessment date will be on \_\_\_\_\_  
NEXT REASSESSMENT DATE
3. I/We continue to need an AAP benefit and/or Medi-Cal coverage for the above named child. I am/we are requesting an increase in the AAP benefit because the needs of the child have changed. I am/we are providing the agency the following information to assist the agency in determining whether or not increased assistance will be granted, and if so, in what amount. (Please complete Section I.)
4. I/We continue to need an AAP benefit and/or Medi-Cal coverage for the above named child. I/We request that the AAP benefit for the above named child be decreased to \$\_\_\_\_\_ because the needs of the child have changed. I/We understand if at anytime the child's needs change we may contact the agency to renegotiate the AAP benefit.

