ATTACHMENT B MODEL FORM

For District Use _____ **Date sent:** **/ /**

Child's Name: _____

Parental Certification of Continued Support and Educational Status of Child

I/We hereby certify that the information provided by me/us is true and accurate to the best of my/our knowledge involving the child listed below for whom I/we are receiving monthly adoption subsidy payments for him/her from _____ County Department of Social Services.

PLEASE PROVIDE MISSING INFORMATION

Child's Name: _____ **Child's Date of Birth:** / /

Date Adoption Finalized: / /

At Home: ☐ Yes ☐ No **Date Left Home:** / /

1. I/We are still legally responsible for the above named child. *(check one)* ☐ Yes ☐ No
2. I/We continue to provide any support for him/her. *(check one)* ☐ Yes ☐ No
3. To be completed **only** where the adopted child is school-age in accordance with the laws where the adopted child resides. The above named child is: *(check only one box)*. ☐ Yes ☐ No

   ☐ **a full-time elementary or secondary student;**

   ☐ **has completed secondary education; or**

   ☐ **not attending school full time.**

   If the above named child has not completed secondary education, please check the box which best describes his or her educational status:

   ☐ **enrolled, or in the process of enrolling, in a school which provides elementary or secondary education**

   School Name and Address: _____

   _____

   _____

   School district name: _____

   _____

   _____

For District Use: _____ **Date sent:** ____ / ____ / ____

Child's Name: _____

☐ **instructed in elementary or secondary education at home.**

Name and address of supervising school: _____

_____

_____

☐ **in an elementary or secondary independent study education program, administered by the local school or school district.**

Name and address of administering school or school district: _____

_____

_____

☐ **incapable of attending school on a full-time basis due to the adopted child's medical condition.**

(*If this box is checked, please submit as part of this certification, information which describes the incapacity that prevents full time school attendance. The child's condition must be documented by a physician, or a physician's assistant or nurse practitioner under the supervision of a physician, or a licensed psychologist).*

Please sign below and complete information with current address and telephone number. Your reply is appreciated no later than ____ / ____ / ____ .

Signatures: _____

(Adoptive Parent 1) (Adoptive Parent 2)

Date: ____ / ____ / ____ / ____ /

Address: _____

Street Address

_____

City State Zip Code

Telephone #: ( ) _____

(Area Code)

A prepaid envelope is enclosed for the return of this document. If there are questions, please contact:

_____, at ( ) _____ .