DEPARTMENT OF HUMAN SERVICES

Bulletin

NUMBER
#18-68-14

DATE
August 6, 2018

OF INTEREST TO
County Directors

Social Services Supervisors and Staff

Tribal Directors

Tribal Social Services Supervisors and Staff

ACTION/DUE DATE
Please read information and implement

EXPIRATION DATE
August 6, 2020

Minnesota Proof of Foster Care

TOPIC

Proof of foster care for youth exiting foster care.

PURPOSE

Provides verification for foster youth who have been in care and are aging out between the ages of 18 up to 21.

CONTACT

Nicolas Vogel, program consultant

(651) 431-4707 or nicolas.vogel@state.mn.us

SIGNED

NIKKI FARAGO
Assistant Commissioner
Children and Family Services Administration

TERMINOLOGY NOTICE

The terminology used to describe people we serve has changed over time. The Minnesota Department of Human Services (DHS) supports the use of "People First" language.

I. Background

According to the Family First Prevention Services Act, (Public Law 115-123) as of February 9, 2018, a Title IV-E agency responsible for placement must provide a youth in foster care with any official documentation necessary to prove that they were previously in foster care. This must be done before a youth ages out of care (Social Security Act, section 475(5)(I)).

II. Instructions

The attached form is being made available to ensure compliance with the Family First Prevention Services Act. County and tribal social services may provide this form to youth aging out of foster care between the ages of 18 up to 21. Proof of foster care may be necessary for youth to prove eligibility for programs or benefits such as Medicaid (Medical Assistance).

Americans with Disabilities Act (ADA) Advisory

This information is available in accessible formats for people with disabilities by calling (651) 431-3725 (voice) (division's general information phone number) or toll free at (800) 627-3529 (include if available within the division) or by using your preferred relay service. For other information on disability rights and protections, contact the agency's ADA coordinator.

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Minnesota Proof of Foster Care

Purpose: This form is used by county or tribal social service staff to verify foster care placements.

Youth's Name:	DOB:

- ☐ Youth was in a Minnesota foster care placement in _____ (county/tribal agency)
- ☐ Youth was under state or tribal guardianship

Dates of placement: _____ to _____

Authorized Signature:	Date:
Print Name:	Telephone Number:
Title:	Email Address:
Authorized Agency:	