# APPROVED SUBSIDY MAINTENANCE FORM

**Foster Care (For Sub Guardian Cases)**

<table>
<thead>
<tr>
<th>Case ID:</th>
<th>Adoption Assistance</th>
<th>Case ID:</th>
<th>Last, First Mi:</th>
</tr>
</thead>
</table>

### CM-51 ENTRY

- **Adoption Finalization/Guardianship Transfer Date:** ___/___/____
- **Amendment Date:** ___/___/____
- **Graduation Date:** ___/___/____

- **Approved Subsidy Services:**
  - [ ] Adoption Assistance
  - [ ] Subsidized Guardianship
  - [ ] Ongoing Monthly Payment Amount: _____________
  - [ ] Nonrecurring Expenses Amount: _____________
  - [ ] Therapeutic Day Care
    - [ ] Part-Time
    - **Full-Time Daily Rate:** _____________
    - **Start Date:** ___/___/____
    - **End Date:** ___/___/____
  - [ ] Day Care For Children Under Age 3
    - [ ] Part-Time
    - **Full-Time Daily Rate:** _____________
    - **Start Date:** ___/___/____
    - **End Date:** ___/___/____
  - [ ] Respite Care For DSCC Otherwise Eligible Child

### CM-52 ENTRY

- **Payment For Pre-Existing Conditions Not Payable Elsewhere At Medicaid-Eligible Rates**

  - [ ] Counseling
    - **Units:** ____
    - **Rate:** ____
    - **Frequency:** ____
    - **Start Date:** ___/___/____
    - **End Date:** ___/___/____
  - [ ] Therapy
    - **Units:** ____
    - **Rate:** ____
    - **Frequency:** ____
    - **Start Date:** ___/___/____
    - **End Date:** ___/___/____
  - [ ] Other
    - **Units:** ____
    - **Rate:** ____
    - **Frequency:** ____
    - **Start Date:** ___/___/____
    - **End Date:** ___/___/____

  (Specify: _____________)

  - [ ] Other
    - **Units:** ____
    - **Rate:** ____
    - **Frequency:** ____
    - **Start Date:** ___/___/____
    - **End Date:** ___/___/____

  (Specify: _____________)

### CM-53 (DIRECTOR’S AUTHORIZED SERVICES)

- **Service:**
  - **Units:** ____
  - **Rate:** ____
  - **Frequency:** ____
  - **Start Date:** ___/___/____
  - **End Date:** ___/___/____

  **Amount:** __________

- **Service:**
  - **Units:** ____
  - **Rate:** ____
  - **Frequency:** ____
  - **Start Date:** ___/___/____
  - **End Date:** ___/___/____

  **Amount:** __________

  **Payment For Pre-Existing Conditions Not Payable Elsewhere At Medicaid-Eligible Rates**

  - **Service:**
    - **Units:** ____
    - **Rate:** ____
    - **Frequency:** ____
    - **Start Date:** ___/___/____
    - **End Date:** ___/___/____

  **Amount:** __________

- **Print Name of Child’s Assigned Permanency worker**

- **Worker’s Signature**

- **DATE**