ARIZONA DEPARTMENT OF CHILD SAFETY

KINSHIP FOSTER CAREGIVER STIPEND REQUEST

The Kinship Foster Caregiver Stipend (formerly called the Grandparent Stipend) is a monthly payment of approximately $75 (per child) available to eligible kinship foster caregivers who have taken a related child(ren) in the custody of the Department of Child Safety (DCS) into their home. A Kinship Foster Caregiver includes a grandparent, any level of a great-grandparent, an aunt or uncle, or any other adult relative with whom the Department of Child Safety has placed a related foster child. Kinship Foster Caregivers may become licensed as foster parents in order to receive additional financial and other supports to assist in providing 24/7 care for the related child in their care. When a Kinship Foster Caregiver becomes licensed as a foster parent, the Kinship Foster Caregiver is no longer eligible for this stipend.

Am I Eligible? Kinship Foster Caregivers are eligible if they are not receiving a licensed foster home payment, or an adoption subsidy or guardianship subsidy payment for the child AND if their annual household income is **less than** 200% of the current Federal Poverty Level (FPL). The family size and annual household income reported on this form will be compared to the **current** published FPL guideline to determine eligibility. The chart below is an example, based on the 2017 FPL.

Note: If you are unsure if you meet the income requirements, please submit your application. You will be notified if your household income exceeds the current threshold for your family size.

Family Size	Maximum Annual Income	Family Size	Maximum Annual Income
1 person	$23,760	4 persons	$48,600
2 persons	$32,040	5 persons	$56,880
3 persons	$40,320	6 persons	$65,160

Record your family size and annual household income in the space below. Family size includes yourself, your spouse and minor children, and children placed by DCS in your home. Annual household income includes your income, your spouse's income, and any income received for children under age 18 in your care (i.e. social security payments, child support, etc.)

Family size:	Annual household income:

Enter the name and date of birth for each related child in DCS custody for whom you are providing 24/7 care:

CHILD'S NAME *(PLEASE PRINT)*	DATE OF BIRTH	CHILD'S NAME *(PLEASE PRINT)*	DATE OF BIRTH
Child #1:		Child #3:	
Child #2:		Child #4:	

Sign and return this form to: DCS-Kinship Foster Caregiver Stipend Program, PO. Box 6030, S/C CH 010-22, Phoenix, AZ 85005, or by email to Kinshipstipend@azdcs.gov. If you have a questions about this or other kinship support available, please call the DCS Kinship Care Specialist at 1-877-KIDSNEEDU Option 3 or 1-877-543-7633 Option 3.

NAME OF KINSHIP FOSTER CAREGIVER (PLEASE PRINT)	ADDRESS (PLEASE PRINT)	PHONE NO.	EMAIL
I swear under penalty of perjury that the information provided as it relates to my eligibility for benefits, is true and correct to the best of my knowledge.	SIGNATURE		DATE

Equal Opportunity Employer/Program • Under Titles VI and VII of the Civil Rights Act of 1964 (Title VI & VII), and the Americans with Disabilities Act of 1990 (ADA), Section 504 of the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, and Title II of the Genetic Information Nondiscrimination Act (GINA) of 2008; the Department prohibits discrimination in admissions, programs, services, activities, or employment based on race, color, religion, sex, national origin, age, disability, genetics and retaliation. The Department must make a reasonable accommodation to allow a person with a disability to take part in a program, service or activity. For example, this means if necessary, the Department must provide sign language interpreters for people who are deaf, a wheelchair accessible location, or enlarged print materials. It also means that the Department will take any other reasonable action that allows you to take part in and understand a program or activity, including making reasonable changes to an activity. If you believe that you will not be able to understand or take part in a program or activity because of your disability, please let us know of your disability needs in advance if at all possible. To request this document in alternative format or for further information about this policy, contact your local office. TTY/TDD Services: 7-1-1. • Free language assistance for Department services is available upon request.