FOSTER CARE CONTINGENCY FUND CLAIM FORM

LOCALITY NAME WHO HAS CUSTODY OF CHILD(REN) INVOLVED:

Child Placing Agency Name (if applicable)

Is a W-9 included with this request? ○ Yes ○ No Date

FOSTER PARENT (S) INFORMATION

First Name Last Name Social Security Number:

First Name Last Name Social Security Number:

Street Address: State: Zip Code: Home Phone:

Did Foster Parents/CPA file Insurance Claim? ☐ Yes ☐ No

Date Foster Parent Discovered Damage: If so, what was the amount of the deductible?:

Names/Ages of Foster Children involved:

AGENCY INFORMATION

Agency Worker First Name: Last Name: Phone Number:

Street Address: State: Zip Code: City/County:

Date Worker Received Initial Damage Report: Date Worker Observed Damage(s):

Describe How and What Was Damaged:

Precautionary Measure to Prevent Recurrence:

(1) Foster Parent Signature ______________________ Date

(2) Foster Parent Signature ______________________ Date

Worker's Signature ______________________ Date

Director's (or) Designee's Signature ______________________ Date

Total Amount Requested:

*** ALL INFORMATION ON THE FORM MUST BE COMPLETED IN ORDER TO PROCESS CLAIM REQUEST***

Submit Form to: Your Regional Resource Family Consultant