**Foster Parent Insurance Program Verification of Claim**

**Use of form:** Completion of this form is required before a claim for foster parent insurance can be made to the department. The form must be completed by the licensing agency to verify the claim details submitted by the foster parent. Personal information you provide may be used for secondary purposes [Privacy Law, s. 15.04(1)(m), Wisconsin Statutes].

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Placing Agency Information** | | | | | | | | |
| Placing Agency Name | | | | | | | | |
| Placing Agency Address (Street, City, State, Zip Code) | | | | | | | | |
| **Foster Parent(s) Information** | | | | | | | | |
| Foster Parent(s) Name | | | | | | | | |
| Foster Parent(s) Address (Street, City, State, Zip Code) | | | | | | | | |
| **Date DCF-F-CFS0116-E was received by the licensing agency:** | | | | | | | | |
| Yes | | No | | Was the foster parent licensed at the time of occurrence? | | | | |
| Yes | | No | | Was the foster child placed in the home at the time of occurrence? | | | | |
| Yes | | No | | Did the foster parent have a previous claim submitted during this state fiscal year? | | | | |
|  | |  | | If “Yes” provide: Date of previous claim: | | | | |
|  | |  | | Amount of previous claim: $ | | | | |
| Explain what you understand the circumstances of loss or damage to be. | | | | | | | | |
| Describe how you verified the loss or damage. | | | | | | | | |
| **Licensing Agency Recommendation** | | | | | | | | |
|  | Pay amount claimed on DCF-F-CFS0116-E. | | | | | | | |
|  |  | | Amount claimed: | | $ | | | |
|  |  | | Less deductible: | | $ | | | |
|  |  | | Proposed payment: | | $ | | | |
|  | | | | | | | | |
|  | Pay amount other than claimed. | | | | | | | |
|  |  | | Amount claimed: | | $ | | | |
|  |  | | Less deductible: | | $ | | | |
|  |  | | Proposed payment: | | $ | | | |
|  | | | | | | | | |
|  | Disregard claim. | | | | | | | |
|  | | | | | | | | |
| If amount other than claimed is to be paid or claim is to be disregarded, provide explanation of recommendation. | | | | | | | | |
|  | | | | | | | | |
| **Signature** | | | | | | | | |
|  |  | | | | |  |  |  |
|  | Agency Representative Name | | | | |  | Telephone Number |  |
|  |  | | | | |  |  |  |
|  | Agency Representative Signature | | | | |  | Date Signed |  |