

**FOSTER PARENT INSURANCE PROGRAM  
VERIFICATION OF CLAIM**

**Use of form:** Completion of this form is required before a claim for foster parent insurance (s. 48.627) can be made to the department. The form must be completed and signed by the placing agency. Personal information you provide may be used for secondary purposes [Privacy Law, s. 15.04(1)(m), Wisconsin Statutes].

**Instructions:** Within five working days of receipt, submit a "Foster Parent Insurance Program Claim of Loss or Damage" form (DCF-F-CFS0116-E) with supporting documentation and the completed "Foster Parent Insurance Program Verification of Claim" form (DCF-F-CFS0117-E) to: Foster Parent Insurance Claims  
DCF/DSP – Room E200  
P.O. Box 8916  
Madison, WI 53708-8916

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**Placing Agency Information**

Name – Placing Agency \_\_\_\_\_

Address (Street, City, State, Zip Code) \_\_\_\_\_

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**Foster Parent(s) Information**

Name – Foster Parent(s) \_\_\_\_\_

Address (Street, City, State, Zip Code) \_\_\_\_\_

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**Date DCF-F-CFS0116-E was received by the placing agency:** \_\_\_\_\_ (mm/dd/yyyy)

- 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 If appropriate, is restitution being sought?  
 Yes  No Is the foster child FFP eligible?

If "Yes" provide: Date of previous claim: \_\_\_\_\_ (mm/dd/yyyy)

Amount of previous claim: \$ \_\_\_\_\_

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Explain what you understand the circumstances of loss or damage to be.

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Describe how you verified the loss or damage.

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Explain how future loss or damage by the foster child can be prevented and how the condition is being treated or resolved.

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**Placing Agency Recommendation**

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Pay amount claimed on DCF-F-CFS0116-E.

Amount claimed: \$ \_\_\_\_\_

Less deductible: \$ \_\_\_\_\_

Recommended payment: \$ \_\_\_\_\_

Pay amount other than claimed.

Amount claimed: \$ \_\_\_\_\_

Less deductible: \$ \_\_\_\_\_

Recommended payment: \$ \_\_\_\_\_

Disregard claim.

If amount other than claimed is to be paid or claim is to be disregarded, provide explanation of recommendation.

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**Placing Agency Verification Checklist**

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Yes  No Are all three pages of the DCF-F-CFS0116-E completed and attached?

Yes  No Is there documentation of insurance coverage or insurance disclaimer provided with the DCF-F-CFS0116-E?

Yes  No Have the receipts, estimates or other documentation for each item lost or damaged been provided?

Yes  No If theft was involved, has a copy of the police report been provided?

Yes  No Has the DCF-F-CFS0117-E been completed in its entirety?

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**Signature**

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\_\_\_\_\_  
Name – Person Completing This Form

\_\_\_\_\_  
Telephone Number

\_\_\_\_\_  
**SIGNATURE** – Agency Representative

\_\_\_\_\_  
Date Signed