

Kinship Care Caretaker Application

Use of form: Use of this form by Kinship Care applicants is mandatory under Wisconsin Statutes 48.57(3m)(a)1., and constitutes one portion of a completed application for a new assessment or reassessment of Kinship Care eligibility. Personal information you provide may be used for secondary purposes [Privacy Law, s.15.04(1)(m), Wisconsin Statutes]. Failure of applicants to comply shall result in a denial of Kinship Care benefits.

Provision of your social security number (SSN) is mandatory per Wis. Stat. 48.57(3p)(e). Your SSN will be used to conduct background checks. If you do not provide it, your application for Kinship Care benefits may be denied.

Instructions: The applicant completes the Kinship Care application and submits the completed form to the department or its designee along with any other materials necessary for eligibility determination of Kinship Care payments.

Reassessment New

I. CARETAKER INFORMATION

Name – Applicant (Last, First, MI)	Birthdate (mm/dd/yyyy)	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female
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Other Names Used – Include Maiden Names, Nick Names, Aliases

Address (Street, City, State, Zip Code)	Social Security Number
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Telephone Number – Home ()	Ethnic / Racial Group (check all that apply) <input type="checkbox"/> Black (not of Hispanic Origin) <input type="checkbox"/> American Indian / Alaskan Native <input type="checkbox"/> Asian or Pacific Islander <input type="checkbox"/> Hispanic (Mexican, Puerto Rican or Other Spanish Culture) <input type="checkbox"/> White	Origin <input type="checkbox"/> Asian or Pacific Islander <input type="checkbox"/> Black <input type="checkbox"/> American Indian <input type="checkbox"/> White
Telephone Number – Work ()		

What is your relationship to the child on:

Parent 1 side _____ **OR** Parent 2 side _____

Yes No Is the child's parent adjudicated? If "Yes", what is the paternity number? _____

Yes No Are you the child's legal guardian? If "Yes", date of guardianship order: _____

guardianship order number: _____ State: _____

II. CHILD INFORMATION

Name – Child (Last, First, MI)	Birthdate (mm/dd/yyyy)	Age	Social Security Number
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Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Ethnic / Racial Group (check all that apply) <input type="checkbox"/> Black (not of Hispanic Origin) <input type="checkbox"/> American Indian / Alaskan Native <input type="checkbox"/> Asian or Pacific Islander <input type="checkbox"/> Hispanic (Mexican, Puerto Rican or Other Spanish Culture) <input type="checkbox"/> White	Origin <input type="checkbox"/> Asian or Pacific Islander <input type="checkbox"/> Black <input type="checkbox"/> American Indian <input type="checkbox"/> White
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Yes No Does this child receive SSI? If "Yes", enter monthly amount \$ _____

How long has this child lived with you? _____ Yes No Are you currently receiving Kinship Care benefits for this child?

Yes No Do you receive Kinship Care for other children in your home? If "Yes", number of other children: _____

III. PARENT INFORMATION

Name – Parent 1 (Last, First, MI)	Birthdate (mm/dd/yyyy)
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Address (Street, City, State, Zip Code)

Telephone Number – Home ()	Telephone Number – Work ()	Social Security Number
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Name – Parent 2 (Last, First, MI)	Birthdate (mm/dd/yyyy)
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Address – (Street, City, State, Zip Code)

Telephone Number – Home ()	Telephone Number – Work ()	Social Security Number
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IV. OTHER ADULTS LIVING IN YOUR HOME

Name (Last, First, MI)	Birthdate (mm/dd/yyyy)	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Social Security Number
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Other Names Used – Include Maiden Names, Nick Names, Aliases

Relation to Applicant	Ethnic / Racial Group (check all that apply) <input type="checkbox"/> Black (not of Hispanic Origin) <input type="checkbox"/> American Indian / Alaskan Native <input type="checkbox"/> Asian or Pacific Islander <input type="checkbox"/> Hispanic (Mexican, Puerto Rican or Other Spanish Culture) <input type="checkbox"/> (includes Indian Subcontinent Origin) <input type="checkbox"/> White	Origin <input type="checkbox"/> Asian or Pacific Islander <input type="checkbox"/> Black <input type="checkbox"/> American Indian <input type="checkbox"/> White
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Name (Last, First, MI)	Birthdate (mm/dd/yyyy)	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Social Security Number
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Other Names Used – Include Maiden Names, Nick Names, Aliases

Relation to Applicant	Ethnic / Racial Group (check all that apply) <input type="checkbox"/> Black (not of Hispanic Origin) <input type="checkbox"/> American Indian / Alaskan Native <input type="checkbox"/> Asian or Pacific Islander <input type="checkbox"/> Hispanic (Mexican, Puerto Rican or Other Spanish Culture) <input type="checkbox"/> (includes Indian Subcontinent Origin) <input type="checkbox"/> White	Origin <input type="checkbox"/> Asian or Pacific Islander <input type="checkbox"/> Black <input type="checkbox"/> American Indian <input type="checkbox"/> White
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V. OTHER ADULTS EMPLOYED BY YOU IN YOUR HOME

Name (Last, First, MI)	Birthdate (mm/dd/yyyy)	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Social Security Number
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Other Names Used – Include Maiden Names, Nick Names, Aliases

Relation to Applicant	Ethnic / Racial Group (check all that apply) <input type="checkbox"/> Black (not of Hispanic Origin) <input type="checkbox"/> American Indian / Alaskan Native <input type="checkbox"/> Asian or Pacific Islander <input type="checkbox"/> Hispanic (Mexican, Puerto Rican or Other Spanish Culture) <input type="checkbox"/> (includes Indian Subcontinent Origin) <input type="checkbox"/> White	Origin <input type="checkbox"/> Asian or Pacific Islander <input type="checkbox"/> Black <input type="checkbox"/> American Indian <input type="checkbox"/> White
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VI. Explain why the parent cannot take care of the child:

VII. Do you, or any other adult living or working in your home, have any arrests or convictions? If so, list below. (Arrests or background check will be run on all adults in your household.)

Name	Crime	Arrest Conviction	Approximate Date

VIII. DOCUMENTATION

- A. You must provide proof that parent is deceased, incarcerated or institutionalized.
 - 1. If a child's parent is deceased you must attach a copy of the parent's death certificate.
 - 2. If a child's parent is incarcerated or institutionalized you must attach a copy of a letter from the jail, prison, or institution stating that the parent is there.
- B. Copy of Guardianship Order
If you are the legal guardian for the child, send a copy of the guardianship order. Attach all documentation to the completed application.
- C. You are required to provide written proof that the child is living with you. Include the attached Documentation of Child Residence form (DCF-F-CFS2099A), which is an acceptable proof of child's residence if it is completed and signed by an official at the child's school, the child's doctor's office, or the child's day care center. This does not include friends, neighbors and relatives.

Attach all documentation to the completed application and send all material to:

**Kinship Care Program
Professional Services Group, Inc.
1126 South 70th Street, Suite 200
West Allis, WI 53214**

Or, a signed copy of this form may be scanned and emailed to kinship@psgqip.com

IX. CERTIFICATION

I, the undersigned caretaker relative, attest to the following:

1. That neither I, nor any other adult resident of this household, nor any employee who would have regular contact with the minor relative identified above have any arrests or convictions that would adversely affect the minor relative or my ability to care for the relative identified above.
2. That I will notify the agency prior to the habitation of any other adult in my home and prior to employment of any person who would have regular contact with the minor relative identified above.
3. That I will contact the agency prior to or within three (3) working days after the minor relative for whom a Kinship Care payment is made leaves our home.
4. That I will assist the agency to the extent possible in referring the parents of the minor relative identified above to the child support agency.
5. That I will cooperate with the agency in this application process and the annual review process, including applying for any other financial assistance programs for which the minor relative identified above may be eligible.

I understand the questions and statements on this application form. I understand the penalties for giving false information or breaking the rules. I certify that I am aware that if I give false information under oath I may be prosecuted criminally for false swearing. I understand and agree to provide documents to prove what I have said. I understand that the agency may contact other persons or organizations to obtain the necessary proof of my eligibility.

Name – Applicant (print)

SIGNATURE – Applicant

Date Signed

Kinship Care Documentation of Child's Residence

Use of this form: This form is to be completed by someone who knows that this child is living with you and will be used to show proof of a child's residence with a relative applying for Kinship Care. This could be the child's school attendance office personnel, the child's doctor, teacher, day care center or someone similar. It does not include friends, neighbors or relatives. Personal information you provide may be used for secondary purposes [Privacy Law, s.15.04(1)(m), Wisconsin Statutes].
A separate form should be filled out for each child.

Instructions: The form is acceptable as proof of child's residence only if filled out and signed by an agent of the agency providing the address information. Schools, doctor's offices, day care providers, and others having knowledge of a child's residence, should provide the address listed for the child in their records.

Caretaker Applicant (print)

Name – Applicant (Last, First, MI)

Name – Applicant (Last, First, MI)

Address – Child (Street, City, State, Zip Code)

Person Providing Verification (print)

Name – Person Providing Verification

Name – Agency

Telephone Number

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SIGNATURE – Person Providing Verification

Date Signed

The Caretaker Applicant should include this form with the Application for Kinship Care, DCF-F-CFS2099), OR the person completing the form may send this form to:

**Kinship Care Program
Professional Services Group, Inc.
1126 South 70th Street, Suite 200
West Allis, WI 53214**

(A signed copy of this form may be scanned and emailed to kinship@psgqip.com)