Washington State Department of CHILDREN, YOUTH & FAMILIES

Foster Caregiver Reimbursement Claim

CLAIM NUMBER

Total Amount of Claim: $ ____

Filed by: ☐ Licensed Foster Parent ☐ Licensed Kinship ☐ Respite Provider ☐ Unlicensed Placement

Use this form to request reimbursement for damages to property owned by the foster caregiver and/or emergency medical treatment for household members because of an act by a child experiencing foster care who is placed in the home.

Example: A child experiencing foster care throws a remote at the TV, shattering the screen. This is payable under this program because the item was owned by the foster caregiver and the damage was caused by the child experiencing foster care while placed in the home.

I. Foster Caregiver Information

NAME	PROVIDER NUMBER	PHONE NUMBER

MAILING ADDRESS	CITY	STATE	ZIP CODE

II. Child(ren) experiencing foster care who caused damage or emergency medical expenses

NAME	BIRTHDATE	CASE NUMBER

III. Witness

NAME	PHONE NUMBER	EMAIL

SIGNATURE	DATE

IV. Occurrence Information

****Provide photos & receipts****	ITEM 1	ITEM 2	ITEM 3	ITEM 4
Date the damage occurred:				
Item or Injury (TV, broken leg)				
Cleaning cost				
Repair cost				
Comparable replacement cost				
Medical cost				

V. Insurance Information

Will any of the item(s) listed above be paid by a homeowner's, medical, dental, worker's compensation, or other private insurance? ☐ Yes

Out-of-pocket expenses: $	Insurance Company	Policy Number	☐ NA

VI. Narrative

Describe specifically what happened to cause your loss, damage, or injury. Include what supervision was being provided.

I certify or declare, under penalty of perjury under the laws of the State of Washington, that the foregoing is true and correct.

FOSTER CAREGIVER'S SIGNATURE	DATE

TO BE COMPLETED BY THE ASSIGNED DCYF CASEWORKER

☐ I reviewed the claim for accuracy, completeness, timeliness, support documents, and signature.

☐ I agree ☐ I do not agree with payment of this claim.

Reasons you do not agree or additional information regarding this claim:

CASEWORKER'S NAME	FIELD OFFICE	REGION

SIGNATURE	DATE

SEND ALL COMPLETED CLAIMS TO DCYF CAREGIVER CLAIMS AT dcyf.caregiverclaims@dcyf.wa.gov

Foster Caregiver Reimbursement Claim Instructions

TO BE COMPLETED BY THE FOSTER CAREGIVER

Please enter the total amount of the costs entered in section IV. Occurrence Information in the top right box titled "Total Amount of Claim."

Select the appropriate foster home type.

Under section I. Enter the name, provider number, phone number, and mailing address of the foster home.

Under section II. Enter the name, date of birth, and case number of the child(ren) experiencing foster care.

Under section III. Enter the full name and contact information for a witness to the occurrence (if available), and have them sign & date.

Under section IV. Enter the information for up to four (4) items.

For each item provide the date of occurrence, state the specific loss, and enter the cost under the appropriate section.

For Cleaning Costs:

For items that can be cleaned, enter the cost and provide a detailed estimate, invoice, or paid receipt from a vendor.

For Repairs:

For property damage that cannot be cleaned, enter the cost and provide an estimate, invoice, or a paid receipt from a vendor. If the foster caregiver decides to complete the repair on their own, provide an estimate or receipt for materials only.
**Labor costs are not paid when a foster caregiver does their own work, the program will pay for the cost of materials only.*

For Replacements:

For property damage that cannot be cleaned or repaired, enter the cost and provide an estimate or receipt for a comparable replacement (similar model, brand, features, and quality). Estimates can be from a service provider, in-store, or online vendor.
**Please provide original purchase receipt if available.*

For Medical Costs:

For emergency medical, dental, and vision bodily injury (broken leg, etc.), provide the medical bill and insurance statement. For emergency medical, dental, and vision items (prosthetic, braces, eyeglasses, etc.), provide the medical bill, insurance statement, and an estimate or receipt for a comparable replacement.
**Only the initial emergency visit and medical item are covered. Follow-up visits are not covered.*

Other Situations:

Provide a copy of any Incident Reports, letters, or emails about the occurrence. For property damage relating to theft, vandalism, and fire, provide a copy of the police or fire department report and any follow-up investigation findings.

*****Remember to include a photo of the damage and cost documentation (estimate, receipt, invoice) for each item*****

Under section V. Check "Yes" if another insurance policy is available and enter the deductible, company, and policy number OR check "NA" if no other insurance is available for this claim. The program can pay the deductible and out-of-pocket costs for covered items.
**Reimbursement is limited to costs not payable under any privately held insurance or disability benefits law.*

Under section VI. Describe what happened in detail, include what supervision was being provided. Provide an explanation if photos are not available. For claims submitted more than thirty (30) days after an occurrence, include a statement indicating the reason for the delay in submitting the claim. **Claims are not payable if filed after one (1) year of the date of occurrence.*

Sign and date the claim. Digital signatures, typed-in signatures, or having the assigned DCYF caseworker sign on your behalf is accepted when confirmed by an email from you authorizing these types of signatures.

Send the claim, photos, estimates/receipts, and any other supporting documents to the assigned DCYF caseworker.

TO BE COMPLETED BY THE ASSIGNED DCYF CASEWORKER

Ensure the current and correct form is used, found on the DCYF Forms website.

Return the claim to the foster caregiver if an outdated claim form was received, if all the requested information is not provided, if all the required documents were not attached to the claim, or if the claim form was not signed and dated by the foster caregiver.

Attest that you reviewed the claim for accuracy, completeness, timeliness, support documents, and signature.

Select whether you agree or do not agree with payment of this claim.

Enter a statement indicating why you disagree with the claim (if applicable), if the child experiencing foster care was likely to have caused the damage, if you have seen the damaged item personally, and any other relevant information regarding this claim.

Print your name, field office, region, then sign and date.

Attach the claim form, photos, estimates and/or receipts, and any other supporting documents to an email and send to DCYF Caregiver Claims at dcyf.caregiverclaims@dcyf.wa.gov.

This program is governed by RCW 74.13.335 and WAC 110-50-1000 to WAC 110-50-1090

****This instruction page can be but does not have to be submitted with the claim, it is provided for informational purposes only.****