**Foster Parent Insurance Program Claim of Loss or Damage**

**Use of form:** Completion of this form is required before a claim for foster parent insurance can be made to the department. This form outlines the information the foster parent(s) must provide for the department to process their claim. Provision of your social security number (SSN) is voluntary; not providing it could result in an information processing delay. Personal information you provide may be used for secondary purposes [Privacy Law, s.15.04(1)(m), Wisconsin Statutes].

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| Amount of Claim$      |
| Foster Parent(s) Name      |
| Foster Parent(s) Address (Street, City, State, Zip Code)      | Foster Parent(s) Telephone Number      |
| Child Placing Agency      |
| List the name and age of each foster child who contributed to the loss or damage. |
| **Name** |  | **Age** |  |
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| Person Who Suffered Loss Name (If other than foster parent(s))      | Relationship to Foster Parent(s)      |
| Person Who Suffered Loss Address (Street, City, State, Zip Code)      |
| Check the type of insurance carried by the foster parent(s): [ ]  Homeowner [ ]  Renter [ ]  Medical [ ]  Vehicle |
| Date Loss or Damage Occurred      | If loss or damage occurred over a period of time, list beginning and end dates. |
| From  |       |  | To  |       |  |
|  | (mm/dd/yyyy) |  |  | (mm/dd/yyyy) |  |  | (mm/dd/yyyy) |  |
| If insured, will payment be made? [ ]  Yes [ ]  No  | If “yes” payment amount | $      |  |
| Attach documentation from insurance company which verifies payment or denial. |
| Was there a waiver of the homeowners or renter’s liability insurance requirement? [ ]  Yes [ ]  NoIf "Yes", attach a copy of the waiver. |
| **STATEMENT OF CIRCUMSTANCES FOR LOSS OR DAMAGE** |
| Explain how the loss or damage occurred and who was involved. |
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| **ITEMIZATION OF LOSS OR DAMAGE** |
| List each item, the date the loss or damage occurred, and the replacement cost for which you are submitting a claim. Sales receipts, estimates or other documentation for each item listed must be attached. |

| **Item** |  | **Loss/Damage Date****(mm/dd/yyyy)** |  | **Replacement****Cost** | **Or** | **Repair****Cost** |
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| **TOTAL COST:** | $      |  |

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| If claims for a quarter exceed 25% of the total program allocation, all claims for that quarter will be prorated. If funds remain at the end of the state fiscal year (other quarters within the fiscal year did not exceed $15,000), prorated claims in the state fiscal year will be additionally funded at a prorated level to the extent that funds are available. The department makes no guarantee that a prorated claim will be made whole at the end of the state fiscal year. Claims do not carry over into the next state fiscal year.I hereby certify that all statements and information provided are true and correct to the best of my ability. I understand that the licensing agency or representatives of the Wisconsin Department of Children and Families will verify this claim and may contact any parties involved. I understand that I may only claim for loss or damage not covered by any other insurance. I further understand that there is a $100 deductible per state fiscal year (July 1 – June 30). |
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| Foster Parent Signature |  | Social Security Number |  | Date Signed |
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|  |  |       |  |       |
| Foster Parent Signature |  | Social Security Number |  | Date Signed |