**Kinship Care Eligibility Determination**

**Use of form:** This form must be used to notify relative caregivers of their Kinship Care eligibility and appeal/review rights, as required under s. 48.57, Wis. Stats. And Ch. DCF 58.08(8), Admin. Code. Personally identifiable information on this form is used to verify the information necessary for providing benefits. Personal information you provide may be used for secondary purposes [ s. 15.04(1)(m), Wis. Stats.].

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| --- | --- | --- | --- |
| Today’s Date (mm/dd/yyyy) | Name – Agency | | |
| Full Name – Child (Last, First, MI) | | Birthdate – Child (mm/dd/yyyy) | |
| Full Name – Relative Caregiver 1 (Last, First, MI) | | | Telephone Number (Home/Cell) |
| Address – Relative Caregiver 1 (Street, City, State, Zip Code) | | | |
| Email Address | | | |
| Full Name – Relative Caregiver 2 (Last, First, MI) | | | Telephone Number (Home/Cell) |
| Address – Relative Caregiver 2 (Street, City, State, Zip Code) | | | |
| Email Address | | | |

Dear      ,

This letter informs you that your application for kinship care was found to be ineligible due to the following reasons:

There may be additional reasons for your denial:

You may request a review or hearing, please see instructions on the next page. Please contact me with any questions at Email or Phone number.

Sincerely,

Child Welfare Professional

**APPEALS PROCESS**

**REQUEST FOR DIRECTOR REVIEW**

If Kinship Care payments are denied or terminated **based on a criminal background check**, you have a right to request a review by the director of the kinship care agency under s. 48.57, Stats. and Ch. DCF 58.11(1), Admin. Code. **The request must be in writing and must be received no later than 45 days after the date of this notice.**

A written request for review should be sent to the agency director or tribal designee (Ch. DCF. 58.02(11), Admin. Code):

Kinship Care Agency Director

Address

The request should include a short statement about the matter you are requesting a review of and the reason for your request.

**REQUEST FOR HEARING**

You may have a right to request a hearing under s. 48.57, Stats. and Ch. DCF 58.11(2), Admin. Code. Your request for an appeal must be sent **directly to the Division of Hearings and Appeals and must be received no later than forty-five (45) days from the date of this notice.**

The request should include a short statement about the matter you are appealing and the reason for your appeal. Please attach a copy of this notice to your request for a hearing. To submit your request for an administrative hearing under Ch. DCF 58.11(2), Admin. Code:

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| --- | --- | --- |
| ***Send your request via U.S. Mail:***  Division of Hearings and Appeals  P.O. Box 7875  Madison, WI 53707-7875 | ***Hand-deliver your request:***  Division of Hearings and Appeals  4822 Madison Yards Way  Madison, WI 53705 | ***Send your request via Facsimile:***  Division of Hearings and Appeals  (608) 264-9885 |