



### THIRD PARTY CLAIM CHECKLIST

CA Children's Administration

#### TO BE COMPLETED BY FOSTER PARENT

- Complete a current Foster Parent Reimbursement Claim, DSHS 18-400(X). For claims involving others who are not foster care licensed, complete the Third Party Claim, DSHS 18-400A(X).
- Sign and date the above form; forward completed form and attachments to the child's DCFS social worker.
- For property damage/loss item, indicate the original purchase cost, the date originally purchased, and the condition of the time prior to the damage/loss.
- For each item claimed, provide the date of occurrence; state the specific injury or damage/loss item; describe the circumstances of the damage/loss/injury; indicate what supervision was being provided at the time of the incident; the steps taken to prevent the occurrence; and the steps to be taken to protect against similar future occurrences.
- Provide the full name, home address, and contact telephone numbers for all the witnesses (if available) to the damage/loss/injury occurrence.

#### REPAIRS:

- For property damage items, send a repair estimate/cleaning bill detailed and signed by a retailer (to substantiate its repair/cleaning cost or that the item cannot be repaired/cleaned). **NOTE: Labor costs are not paid when a foster parent or third party does their own work; however, we will pay for the cost of materials needed to make the repairs.**

#### AND

- Provide the original purchase receipt for property damage loss items if available. If not available, send the purchase receipt (final bill) for a comparable (like kind and quality) replacement or two retailer estimates for a comparable item.
- For property damage items, send picture(s) which show the damage to the items (includes, but is not limited to, motor vehicles, carpets, floors, windows, doors, walls, and furniture).

#### REPLACEMENTS:

- For property damage items, provide the original purchase receipt or send the purchase receipt (final bill) for a comparable (like kind and quality) replacement.

#### OR

- For property damage items, provide two retailer estimates for a comparable (like kind and quality) replacement or two catalog cut-outs.
- For property damage/loss items relating to theft, vandalism, and fire, send a copy of the police or fire damage report along with any follow-up investigation findings. No police report is needed if total claim loss is less than \$100.00.**

#### THIRD PARTY:

- Foster parents who pay a third party directly assume the risk of not being reimbursed if the claim is not paid at all or for the full requested amount.**
- For third party claims, send documentation which substantiates that a claim was filed under any available policy (copy of any payment made by your insurance company or copy of denial letter received for such coverage). If you do not have any policy to access for coverage on third party claims, send a notarized statement to this effect.

#### TO BE COMPLETED BY DCFS SERVICE WORKER/DDD CASE MANAGERS

- Review claim for accuracy, completeness and timeliness. Return the claim to the foster parent if an outdated claim form was received, if all the requested information is not provided or all the required documents were not attached to the claim, or if the claim form was not signed/dated by the foster parent.
- Indicate the source of funds to be used if the claim is paid, whether you concur with payment of the claim, state the reason(s) why you do or do not concur, and provide any other pertinent information in the service worker section on the back of the claim form.
- Indicate whether a DDD child (not a foster child) caused the damage/loss/injury, if you personally saw the damage/injury, whether you checked to see if the foster parent/respite care provider signed and dated the claim form, provided all the requested information, and attached all the required documents.
- For claims submitted more than ninety (90) days after an occurrence, include a statement indicating the reason for the delay in filing the claim.
- Print your full name, indicate your office, mail stop, and telephone number; and sign and date the claim form.



CA Children's Administration

### THIRD PARTY CLAIM

Private insurance must be accessed first before submitting Third Party Claim.

<b>TOTAL AMOUNT OF CLAIM REQUEST</b> \$
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**Must be filed within sixty (60) days.**

**I. CLAIMANT INFORMATION**

NAME OF CLAIMANT (PRINT)	HOME TELEPHONE NUMBER	WORK TELEPHONE NUMBER	MESSAGE TELEPHONE NUMBER
STREET ADDRESS		CITY	STATE ZIP CODE

IF CLAIMANT IS FILING CLAIM ON BEHALF OF A MINOR OR OTHER HOUSEHOLD MEMBER, WRITE THEIR NAME(S) HERE

**II. FOSTER CHILD(REN) WHO CAUSED DAMAGE, LOSS, OR EMERGENCY MEDICAL EXPENSES**

NAME (PRINT)	HOME TELEPHONE NUMBER	WORK TELEPHONE NUMBER	MESSAGE TELEPHONE NUMBER
STREET ADDRESS		CITY	STATE ZIP CODE

Licensed foster parent to whom the child was assigned at the time of the incident:

NAME (PRINT)	HOME TELEPHONE NUMBER	WORK TELEPHONE NUMBER	MESSAGE TELEPHONE NUMBER
STREET ADDRESS		CITY	STATE ZIP CODE

**II. FOSTER CHILD(REN) WHO CAUSED DAMAGE, LOSS, OR EMERGENCY MEDICAL EXPENSES**

NAME (PRINT) <b>1.</b>	HOME TELEPHONE NUMBER	WORK TELEPHONE NUMBER	MESSAGE TELEPHONE NUMBER
STREET ADDRESS		CITY	STATE ZIP CODE

NAME (PRINT) <b>2.</b>	HOME TELEPHONE NUMBER	WORK TELEPHONE NUMBER	MESSAGE TELEPHONE NUMBER
STREET ADDRESS		CITY	STATE ZIP CODE

Describe specifically what happened to cause your loss, damage, or injury. Describe surrounding circumstances and the actions of other participants. Was it accidental or intentional? Identify any purported negligence which may have caused this loss, damage, or injury.

**WITNESS(ES): IF MORE SPACE IS NEEDED, ATTACH ADDITIONAL PAGES (IF APPROPRIATE)**

NAME	TELEPHONE NUMBER	ADDRESS

**DISTRIBUTION:**

White – Children's Administration, PO Box 45710, Olympia WA 98504-5710 Yellow - Foster Parent/Respite Provider Pink - Child's Service Record Goldenrod - Licensing Record.

Do you have homeowners insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, complete the following information:		Do you have homeowners insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, complete the following information:	
NAME OF INSURANCE COMPANY		NAME OF INSURANCE COMPANY	
POLICY NUMBER	TELEPHONE NUMBER	POLICY NUMBER	TELEPHONE NUMBER

**III. REQUIRED DOCUMENTATION (COMPLETE THIS SECTION ON A SEPARATE FORM FOR ADDITIONAL ITEMS)**

**Payment will not be made without documentation proving claim.  
Depreciation and fair determination of payment will be determined by the claim.**

	ITEM 1	ITEM 2	ITEM 3	DOCUMENTATION ATTACHED
Date of occurrence (for each item)				
<input type="checkbox"/> Identify property damaged (if fire, a fire department reports is required)				<input type="checkbox"/> Yes <input type="checkbox"/> No
Original cost				<input type="checkbox"/> Yes <input type="checkbox"/> No
Age of item				<input type="checkbox"/> Yes <input type="checkbox"/> No
Cost of repair or replacement *				<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Identify property lost/stolen (police report is required)				<input type="checkbox"/> Yes <input type="checkbox"/> No
Original cost				<input type="checkbox"/> Yes <input type="checkbox"/> No
Age of item				<input type="checkbox"/> Yes <input type="checkbox"/> No
Cost of replacement *				<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Emergency medical cost				<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Legal defense cost				<input type="checkbox"/> Yes <input type="checkbox"/> No

LOCATION OF COURTHOUSE	DOCKET NUMBER	DATE JUDGMENT ENTERED
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\* For replacement or repairs to home or property, attach two estimates or final bill including contractor or retailer name and telephone number. If unrepairable, provide a written repair statement from a retailer stating that it is unrepairable and an estimate of the replacement cost.

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

FOSTER PARENT'S SIGNATURE	DATE
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**TO BE COMPLETED BY A DIVISION OF CHILDREN AND FAMILY SERVICES (DCFS) SOCIAL WORKER**

1. Source of funds:  IV-E  State      I  concur  do not concur with payment of this claim.

2. ADDITIONAL INFORMATION REGARDING THIS CLAIM	<p><b>THE FOLLOWING STATEMENTS MUST BE ADDRESSED.</b></p> <p>3. I have personally seen the damage. <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>4. I have checked this claim to assure:</p> <p style="margin-left: 20px;">a. that the claimant signed it. <span style="float: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</span></p> <p style="margin-left: 20px;">b. that the claimant provided all documentation. <span style="float: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</span></p>
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5. SOCIAL WORKER'S NAME (PRINT)	FIELD OFFICE	MAIL STOP	REGION
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SERVICE WORKER/DDD CASE MANAGER'S SIGNATURE	TELEPHONE NUMBER	DATE
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