DIVISION OF CHILDREN AND FAMILY SERVICES (DCFS)
DIVISION OF DEVELOPMENTAL DISABILITIES (DDD)

THIRD PARTY CLAIM CHECKLIST

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 it 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.

THIRD PARTY CLAIM

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

TOTAL AMOUNT OF CLAIM REQUEST
$

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)	HOME TELEPHONE NUMBER	WORK TELEPHONE NUMBER	MESSAGE TELEPHONE NUMBER
1.			
STREET ADDRESS	CITY	STATE	ZIP CODE
NAME (PRINT) 2.	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? ☐ Yes ☐ No If yes, complete the following information:		Do you have homeowners insurance? ☐ Yes ☐ 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)				
☐ Identify property damaged (if fire, a fire department reports is required)				☐ Yes ☐ No
Original cost				☐ Yes ☐ No
Age of item				☐ Yes ☐ No
Cost of repair or replacement *				☐ Yes ☐ No
☐ Identify property lost/stolen (police report is required)				☐ Yes ☐ No
Original cost				☐ Yes ☐ No
Age of item				☐ Yes ☐ No
Cost of replacement *				☐ Yes ☐ No
☐ Emergency medical cost				☐ Yes ☐ No
☐ Legal defense cost				☐ Yes ☐ No

LOCATION OF COURTHOUSE	DOCKET NUMBER	DATE JUDGMENT ENTERED

* 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

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

THE FOLLOWING STATEMENTS MUST BE ADDRESSED.

3. I have personally seen the damage. ☐ Yes ☐ No
4. I have checked this claim to assure:
   a. that the claimant signed it. ☐ Yes ☐ No
   b. that the claimant provided all documentation. ☐ Yes ☐ No

5. SOCIAL WORKER'S NAME (PRINT)	FIELD OFFICE	MAIL STOP	REGION
SERVICE WORKER/DDD CASE MANAGER'S SIGNATURE	TELEPHONE NUMBER	DATE	