OFFICE OF CHILDREN YOUTH AND FAMILIES

MOTHER/INFANT FOSTER CARE INFORMATION

I. MINOR PARENT:

MINOR PARENT'S NAME (LAST, FIRST, M.I.):	DATE OF BIRTH:	SOCIAL SECURITY NUMBER:

II. BIOLOGICAL CHILD:

CHILD'S NAME (LAST, FIRST, M.I.):	DATE OF BIRTH:	SOCIAL SECURITY NUMBER:

III. CHILD INFORMATION:

CHILD'S SEX:

- ❒ FEMALE
- ❒ MALE

HISPANIC/LATINO ORIGIN:

- ❒ YES ❒ NO
- ❒ UNABLE TO DETERMINE

CHILD'S RACE:

- ❒ WHITE
- ❒ BLACK
- ❒ AMERICAN INDIAN/ALASKAN NATIVE
- ❒ ASIAN
- ❒ PACIFIC ISLANDER
- ❒ OTHER:_____
- ❒ UNABLE TO DETERMINE

IV. CHILD'S MEDICAL INSURANCE:

❒ CHILD'S MEDICAL INSURANCE IS SAME AS MINOR PARENT

❒ CHILD'S MEDICAL INSURANCE IS DIFFERENT FROM MINOR PARENT, PROVIDE THE FOLLOWING INFORMATION:

NAME OF MEDICAL INSURANCE CARRIER, E.G., BLUE CROSS, HEALTH MAINTENANCE ORGANIZATION (HMO), TRAVELERS:

ADDRESS OF MEDICAL INSURANCE CARRIER:

❒ POLICY NUMBER ❒ CONTRACT NUMBER ❒ GROUP NUMBER ❒ HMO NUMBER:_____	DEDUCTIBLE AMOUNT IF THERE IS A DEDUCTIBLE: $_____	EFFECTIVE DATE OF POLICY: _____/_____/_____
NAME OF POLICY HOLDER:	SOCIAL SECURITY NUMBER OF POLICY HOLDER: _____-_____-_____	

ADDRESS OF POLICYHOLDER:

ADDRESS WHERE MOTHER/INFANT RESIDE:

V. AGENCY INFORMATION:

NAME OF AGENCY:

ADDRESS:

TELEPHONE NUMBER:

VI. DATES/AUTHORIZATION:

DATE CHILD BECOMES ELIGIBLE FOR TITLE IV-E BENEFITS:

_____/_____/_____

_____	_____	_____
PRINT NAME OF AUTHORIZING AGENT	AUTHORIZING SIGNATURE	DATE