

<b>COMMONWEALTH OF VIRGINIA</b> <b>DEPARTMENT OF SOCIAL SERVICES</b> <b>TITLE IV-E FOSTER CARE &amp; IV-E</b> <b>MEDICAID* APPLICATION</b> <small>*(Separate Medicaid application required for Non-custodial agreement cases)</small>	<b>OASIS Case #</b>	
	<b>Client ID</b>	
	<b>COUNTY/CITY</b>	
	<b>SERVICE WORKER</b>	

I. Identifying Information					
<b>Child's Last Name</b>		<b>First Name</b>		<b>Middle</b>	
<b>Child's Date of Birth</b>		<b>Sex</b>		<b>Race</b>	
<b>SSN</b>		<b>OR</b>	<b>Date SSN Applied for</b>		
<b>Address at Removal</b>					

Parent's Information			
<b>Mother's Last Name</b>		<b>Mother's First Name</b>	
<b>SSN</b>			
<b>Mother's Address at Time of Child's Removal</b>			
<b>Father's Last Name</b>		<b>Father's First Name</b>	
<b>SSN</b>			
<b>Father's Address at Time of Child's Removal</b>			

II. INITIAL COMMITMENT INFORMATION			
(Copy of court order or VPA required to process application)			
COURT ORDER		VOLUNTARY PLACEMENT AGREEMENT (VPA)	
<b>REMOVAL PETITION DATED</b> _____	<b>REQUIRED JUDICIAL LANGUAGE CONTRARY TO THE WELFARE?</b> <input type="checkbox"/> YES <input type="checkbox"/> NO	<b>CHECK VPA TYPE</b>	<b>VPA DATED</b>
<b>COPY ATTACHED?</b> <input type="checkbox"/> YES <input type="checkbox"/> NO	<b>REASONABLE EFFORTS?</b> <input type="checkbox"/> YES	<input type="checkbox"/> TEMPORARY ENTRUSTMENT	(DATE OF LAST REQUIRED SIGNATURE)
<b>INITIAL COURT ORDER DATED</b> _____	<b>DATE OBTAINED</b> _____	<input type="checkbox"/> PERMANENT ENTRUSTMENT	<b>COPY ATTACHED?</b> <input type="checkbox"/> YES <input type="checkbox"/> NO
<b>COPY ATTACHED?</b> <input type="checkbox"/> YES <input type="checkbox"/> NO	<b>NO REQUIREMENT MET?</b> <input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> NONCUSTODIAL AGREEMENT	

III. NON-FINANCIAL INFORMATION	
<b>1. ELIGIBILITY MONTH:</b> _____ (date petition filed alleging abuse/neglect or date judge signs court order—whichever is earlier; date last required signature is obtained on VPA)	<b>2. WAS THE CHILD REMOVED FROM THE HOME OF SPECIFIED RELATIVE WHO HAD LEGAL CUSTODY?</b> <input type="checkbox"/> YES, Date Physically Removed _____ <input type="checkbox"/> NO, Did child live with specified relative who had custody at anytime during the six months prior to the eligibility month? <input type="checkbox"/> YES, Date child lived with specified relative who had legal custody _____ <input type="checkbox"/> NO <b>If someone other than parent had legal custody, attach documentation (if available)</b> <b>(INDIVIDUAL WHO HAS LEGAL CUSTODY AT REMOVAL WILL ALWAYS BE REMOVAL HOME )</b>

III. NON-FINANCIAL INFORMATION --CONTINUED

**3. NAME AND ADDRESS OF INDIVIDUAL WHO HAD LEGAL CUSTODY AT REMOVAL (This is the removal home)**

\_\_\_\_\_

\_\_\_\_\_

RELATIONSHIP TO CHILD \_\_\_\_\_

**4. LIST ALL INDIVIDUALS RESIDING IN THE REMOVAL HOME AT THE TIME OF CHILD'S PHYSICAL REMOVAL FROM THE HOME:**

NAME	Relationship to the child entering foster care	Age
	Foster Care Child	

**5. DEPRIVATION**

**A. DEATH OF A PARENT**  YES  NO  
If yes, which parent(s) \_\_\_\_\_

**B. DISABLED PARENT**  YES  NO  
If yes, which parent(s) \_\_\_\_\_

**C. UNEMPLOYED PARENT (Both parents in the home/neither disabled)**  YES  NO  
If yes, which parent(s) \_\_\_\_\_

**D. CONTINUED ABSENCE FROM HOME OF A PARENT**  YES  NO  
If yes, which parent(s) \_\_\_\_\_

**E. PATERNITY NOT ESTABLISHED**  YES  NO  
Name of putative father if known \_\_\_\_\_

**6. CITIZENSHIP/ALIENAGE DECLARATION (REQUIRED BY LAW UNDER PENALTY OF PERJURY)**

CHILD IS:  U.S.CITIZEN  ALIEN (ALIEN NUMBER \_\_\_\_\_)  UNDOCUMENTED ALIEN  
ENTRY DATE \_\_\_\_\_ (Attach INS documentation)

**7. ENROLLED IN SCHOOL?**  YES  NO  
NAME OF SCHOOL \_\_\_\_\_ CURRENT GRADE LEVEL \_\_\_\_\_

**8. CHILD SUPPORT REFERRAL**

COPY ATTACHED FOR EACH ABSENT PARENT?  YES  NO  
If Good Cause is claimed, explain \_\_\_\_\_

**IV. TITLE IV-E FINANCIAL SCREENING – RESOURCES**

(Indicate amount/value, as appropriate, and date/method verified)

PROPERTY OWNED (List resources of FC child, parents, and any minor sibling who resided in the removal home at time of child’s physical removal)	FC CHILD	MOTHER/ STEPMOTHER	FATHER/ STEPFATHER	MINOR SIBLINGS
	ELIGIBILITY MONTH	ELIGIBILITY MONTH	ELIGIBILITY MONTH	ELIGIBILITY MONTH
	0	0	0	0
<b>CASH</b>				
CHECKING ACCT (name of bank, account #, current balance)				
SAVINGS ACCT (name of bank, account #, current balance)				
IRA/CD (name of bank, account #, current amount available)				
STOCKS/BONDS (current amount available)				
TRUST FUND (current amount available)				
BURIAL FUND (current value)				
LIFE INSURANCE (name of company, policy #, cash value)				
VEHICLE (year, make, model, equity value)				
OTHER (specify type of resource and date/method of verification)				

**V. TITLE IV-E FINANCIAL SCREENING - INCOME**

(Indicate amount and how often received, if applicable, and date/method verified)

INCOME RECEIVED (List income of FC child, parent, and any minor sibling who resided in the removal home at time of child’s physical removal)	FC CHILD	MOTHER/ STEPMOTHER	FATHER/ STEPFATHER	MINOR SIBLINGS
	ELIGIBILITY MONTH	ELIGIBILITY MONTH	ELIGIBILITY MONTH	ELIGIBILITY MONTH
	0	0	0	0
<b>EARNED</b>				
SSA				
SSI				
VETERANS BENEFITS				
SUPPORT				
RETIREMENT/PENSIONS				
MILITARY ALLOTMENT				
UNEMPLOYMENT COMPENSATION				
WORKER'S COMPENSATION				
OTHER (Specify)				

IF STEPPARENT IS LIVING IN REMOVAL HOME AND IS PAYING CHILD SUPPORT, INDICATE AMOUNT OF CHILD SUPPORT PAID DURING ELIGIBILITY MONTH:

## VI. PLACEMENT INFORMATION

### TYPE OF PLACEMENT

- Foster Home                       CPA Foster Home                       Residential Facility  
 Public Institution Serving 25 or Less                       Other \_\_\_\_\_

PLACEMENT NAME & ADDRESS \_\_\_\_\_

IF THE CHILD IS A QUALIFIED ALIEN, IS PLACEMENT WITH AN UNQUALIFIED ALIEN FOSTER PARENT?  YES  NO

### DATE OF PLACEMENT

Approved FROM \_\_\_\_\_ TO \_\_\_\_\_

Verification Attached? (Checklists, Certifications, Licenses, etc)  YES  NO

### MONTHLY MAINTENANCE COSTS (Indicate applicable foster home rate, child placing agency rate or residential rate)

FC CHILD \_\_\_\_\_ CHILD OF FC CHILD (If applicable) \_\_\_\_\_

COPY OF FINANCIAL AGREEMENT ATTACHED  YES  NO

## VII. MEDICAL INFORMATION AND ASSIGNMENT OF RIGHTS

DOES THE CHILD HAVE MEDICAL INSURANCE?  YES  NO

If yes, provide the following information:

1. Name and address of Insurance Company \_\_\_\_\_

2. Policy Holder	3. Policy Number	4. Coverage Type	5. Effective Date
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DOES THE CHILD HAVE UNPAID MEDICAL BILLS INCURRED DURING THE THREE MONTHS PRIOR TO APPLICATION?

YES  NO  UNKNOWN

If yes, attach sheet showing income and resources during the three months prior to application.

If yes, give the date of each expense was incurred.

### ADDRESS TO WHICH THE MEDICAID CARD SHOULD BE SENT

(Name) \_\_\_\_\_ (Address) \_\_\_\_\_ (City, State, Zip) \_\_\_\_\_

**IN ORDER TO RECEIVE MEDICAID, EACH FOSTER CHILD MUST HAVE HIS/HER RIGHTS TO MEDICAL SUPPORT ASSIGNED TO THE DEPARTMENT OF MEDICAL ASSISTANCE SERVICES (DMAS). THIS MEANS THAT DMAS MUST BE REIMBURSED FOR PAYMENT OF ANY MEDICAL SERVICES RECEIVED FROM ANOTHER INSURER.**

- I AGREE TO ASSIGN THE RIGHTS OF THE ABOVE NAMED FOSTER CHILD FOR WHOM I HAVE THE LEGAL RIGHT TO  
 I REFUSE TO ASSIGN THE RIGHTS OF THE ABOVE NAMED FOSTER CHILD.

**MY SIGNATURE BELOW AUTHORIZES MEDICAID, FAMIS, AND DMAS CONTRACTORS TO EXCHANGE INFORMATION RELATING TO THIS CHILD'S COVERAGE WITH LOCAL EDUCATIONAL AGENCIES. I UNDERSTAND THAT THIS EXCHANGE OF INFORMATION IS NECESSARY TO ASSIST WITH THE APPLICATION, ADMINISTRATION, AND BILLING FOR SERVICES PROVIDED IN SCHOOLS AND THAT I CAN REVOKE THIS CONSENT TO DISCLOSE INFORMATION AT ANY TIME.**

\_\_\_\_\_

Service Worker

\_\_\_\_\_

Supervisor(optional)

\_\_\_\_\_

DATE

\_\_\_\_\_

DATE