



# Foster Parents/Relative Caregivers Notice of Claim

## Foster Parent/Relative Caregivers Information

Name(s): \_\_\_\_\_ Provider number: \_\_\_\_\_  
 Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Home phone number: \_\_\_\_\_ Work phone number: \_\_\_\_\_  
 Name of child in DHS custody: \_\_\_\_\_ Case Number: \_\_\_\_\_  
 Date of birth: \_\_\_\_\_ Branch name: \_\_\_\_\_  
 Name of child's worker: \_\_\_\_\_ Phone number: \_\_\_\_\_  
 Name of certifier: \_\_\_\_\_ Phone number: \_\_\_\_\_

My home is certified by:  DHS or  Other\*: \_\_\_\_\_

**\*If not certified by the Department of Human Services, attach a copy of the certificate.**

Exact date of loss: \_\_\_\_\_ Location of loss: \_\_\_\_\_

Describe in detail how the loss occurred. If there is not enough room, please attach a separate sheet.

Provide photos and two (2) estimates of repairs with your claim. Remember: your claim must be submitted to the Risk Management Division within **90 days** of loss (address below).


List Items Damaged by the Child in DHS Custody	Cost When Purchased	Date of Purchase	Cost to Repair or Replace
1.			
2.			
3.			
4.			
5.			

List specific injury and how it was sustained	Treating physician/hospital	Cost of medical treatment
1.		
2.		

Owner of property damaged and/or name of injured person, if not the foster parents/relative caregivers:

Street Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Phone Numbers: ( ) \_\_\_\_\_ Work: ( ) \_\_\_\_\_ Cell: ( ) \_\_\_\_\_

**READ BEFORE SIGNING:** The loss or damage I claim resulted from the acts of the child named above. In presenting this claim, I attest to the truth and accuracy of this statement, the facts I have presented, and the damages claimed.

 \_\_\_\_\_ Date \_\_\_\_\_  
 Signature of foster parent/relative caregiver, or person making this claim

Written notice of claim must be submitted to the Department of Administrative Services, Risk Management Division, **within 90 days of the loss** (ORS 30.298).

**Fax:** (503) 373-7337 **Mail to:** Risk Management Division  
 1225 Ferry Street SE, U150  
 Salem, Oregon 97301-4287

THIS FORM IS AVAILABLE IN ALTERNATE FORMAT UPON REQUEST

## FILING A CLAIM

### When a foster child injures foster parents, residents, or their property:

- The claim must be filed with Risk Management Division within 90 days of the event.
- Payments do not exceed actual cash value for property losses or 'economic' losses for injury.
- Economic means medical bills, loss of wages, and other documented out-of-pocket expenses.
- If the damage or injury was accidental and unintentional, payments are limited to \$5,000.00 per occurrence.
- Your own medical or disability insurance pays first for injury claims. We pay first for property claims.

### We request this information when you file any claim:

- A brief but detailed account of what happened: Who, what, how, why and where?
- The foster child's name and age.
- The name of the child's caseworker with phone number.
- A daytime phone for you and your home address.

### Property Damage claims also include:

- Photographs of damage, and either receipts or estimates for repair or receipts from the original purchase. (Your photos and receipts can be returned if you request it when you submit them.)
- If your receipts are lost, send a photocopy of the coverage page of the owner's manual or warranty. Tell us when and where and at what cost the item was bought.
- If the damage is structural, provide one or more itemized estimates for repair. The estimates should include the repair person or company, a list of materials, and labor cost per hour. These itemized costs should be equal to the final price.
- Retain the original damaged item until we pay in case we need to inspect.

### Injury Claims should also include:

- Copies of medical bills showing the name and address of the doctor who treated you.
- A signed medical records release form (you can get the form from us).
- Prescription receipts and related expenses with your private insurer's statements showing what was and was not covered.
- A letter verifying your wage loss from your employer and the written excuse from your physician which prescribed that you stay off work.
- Name, address, phone number, and policy number of your private medical, accident, or disability insurance.

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