

COMMONWEALTH OF VIRGINIA DEPARTMENT OF SOCIAL SERVICES	OASIS Case #	
	Client ID	
TITLE IV-E FOSTER CARE & IV-E MEDICAID* APPLICATION	COUNTY/CITY	
	SERVICE WORKER	
*(Separate Medicaid application required for Non-custodial agreement and Non IV-E cases). It is recommended to complete both applications within ten (10) days of the child entering foster care.		

I. Identifying Information

Child's Last Name		First Name		Middle	
Child's Date of Birth		Sex		Race	
SSN		OR		Date SSN Applied for	
Home Address at Removal					

Parent's Information

Parent #1 Last Name		Parent #1 First Name	
SSN		Unqualified Alien?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Parent #1 Address at Time of Child's Removal			
Parent #2 Last Name		Parent #2 First Name	
SSN		Unqualified Alien?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Parent #2 Address at Time of Child's Removal			

II. INITIAL COMMITMENT INFORMATION

(Copy of court order, and applicable affidavit and/or petition, or VPA required to process application)

COURT ORDER		VOLUNTARY PLACEMENT AGREEMENT (VPA)	
REMOVAL PETITION and/or AFFIDAVIT	REQUIRED JUDICIAL LANGUAGE	CHECK VPA TYPE	VPA DATED
DATED _____	CONTRARY TO THE WELFARE?	<input type="checkbox"/> TEMPORARY ENTRUSTMENT	(DATE OF LAST REQUIRED SIGNATURE)
COPY ATTACHED?	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> PERMANENT ENTRUSTMENT	
<input type="checkbox"/> YES <input type="checkbox"/> NO	REASONABLE EFFORTS?	<input type="checkbox"/> NONCUSTODIAL AGREEMENT	COPY ATTACHED?
INITIAL COURT ORDER DATED _____	<input type="checkbox"/> YES <input type="checkbox"/> NO		<input type="checkbox"/> YES <input type="checkbox"/> NO
DATE OBTAINED: _____	REQUIREMENT MET?		
COPY ATTACHED?	<input type="checkbox"/> YES <input type="checkbox"/> NO		
<input type="checkbox"/> YES <input type="checkbox"/> NO			

III. NON-FINANCIAL INFORMATION

1. ELIGIBILITY MONTH: (date petition filed alleging abuse/neglect or date judge signs court order—whichever is earlier; date last required signature is obtained on VPA)	2. WAS CONTRARY TO THE WELFARE MADE AGAINST A SPECIFIED RELATIVE?
	<input type="checkbox"/> Yes; Who was it made against? _____ <input type="checkbox"/> No
	3. WAS THE CHILD REMOVED FROM THE HOME OF THE SPECIFIED RELATIVE THAT CONTRARY TO THE WELFARE WAS MADE AGAINST?
	<input type="checkbox"/> YES, Date Physically Removed _____ <input type="checkbox"/> No, Did child live with specified relative (contrary to the welfare was against) at anytime during the six months prior to the eligibility month?
	<input type="checkbox"/> YES, Date child last lived with specified relative _____ <input type="checkbox"/> NO _____

IV. TITLE IV-E FINANCIAL SCREENING – RESOURCES

(Indicate amount/value, as appropriate, and date/method verified. If there is no reported income document how the family is reportedly making ends meet.)

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	PARENT #1/ STEPPARENT	PARENT #2/ STEPPARENT	MINOR SIBLINGS
	ELIGIBILITY MONTH	ELIGIBILITY MONTH	ELIGIBILITY MONTH	ELIGIBILITY MONTH
CASH				
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	PARENT #1/ STEPPARENT	PARENT #2/ STEPPARENT	MINOR SIBLINGS
	ELIGIBILITY MONTH	ELIGIBILITY MONTH	ELIGIBILITY MONTH	ELIGIBILITY MONTH
EARNED				
SSA				
SSI				
VETERANS BENEFITS				
SUPPORT				
RETIREMENT/PENSIONS				
MILITARY ALLOTMENT				
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: CHILD ONE AMOUNT: _____ CHILD TWO AMOUNT: _____

CHILD CARE EXPENSES PAID BY REMOVAL HOME DURING REMOVAL MONTH:

AGE OF YOUTH: _____ AMOUNT: _____ AGE OF YOUTH: _____ AMOUNT: _____

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

License 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) _____
ENHANCED MAINTENANCE _____
 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:

Name and address of Insurance Company _____

Policy Holder	Policy Number	Coverage Type	Effective Date

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.

Family Services Specialist

Supervisor(optional)

DATE

DATE

ADDITIONAL PLACEMENT INFORMATION	
TYPE OF PLACEMENT <input type="checkbox"/> Foster Home <input type="checkbox"/> CPA Foster Home <input type="checkbox"/> Residential Facility <input type="checkbox"/> Public Institution Serving 25 or Less <input type="checkbox"/> Other _____	
PLACEMENT NAME & ADDRESS _____ _____ _____	
IF THE CHILD IS A QUALIFIED ALIEN, IS PLACEMENT WITH AN UNQUALIFIED ALIEN FOSTER PARENT? <input type="checkbox"/> YES <input type="checkbox"/> NO	
DATE OF PLACEMENT License Approved FROM _____ TO _____ Verification Attached? (Checklists, Certifications, Licenses, etc.) <input type="checkbox"/> YES <input type="checkbox"/> NO	
MONTHLY MAINTENANCE COSTS (Indicate applicable foster home rate, child placing agency rate or residential rate) FC CHILD _____ CHILD OF FC CHILD (If applicable) _____	
ENHANCED MAINTENANCE _____ COPY OF FINANCIAL AGREEMENT ATTACHED <input type="checkbox"/> YES <input type="checkbox"/> NO	

ADDITIONAL PLACEMENT INFORMATION	
TYPE OF PLACEMENT <input type="checkbox"/> Foster Home <input type="checkbox"/> CPA Foster Home <input type="checkbox"/> Residential Facility <input type="checkbox"/> Public Institution Serving 25 or Less <input type="checkbox"/> Other _____	
PLACEMENT NAME & ADDRESS _____ _____ _____	
IF THE CHILD IS A QUALIFIED ALIEN, IS PLACEMENT WITH AN UNQUALIFIED ALIEN FOSTER PARENT? <input type="checkbox"/> YES <input type="checkbox"/> NO	
DATE OF PLACEMENT License Approved FROM _____ TO _____ Verification Attached? (Checklists, Certifications, Licenses, etc.) <input type="checkbox"/> YES <input type="checkbox"/> NO	
MONTHLY MAINTENANCE COSTS (Indicate applicable foster home rate, child placing agency rate or residential rate) FC CHILD _____ CHILD OF FC CHILD (If applicable) _____	
VEMAT _____ COPY OF FINANCIAL AGREEMENT ATTACHED <input type="checkbox"/> YES <input type="checkbox"/> NO	

Af Am
Asian
Hisp
Cauc
Muti-Race
Am Ind
Other
Unk