FAMILY FOSTER CARE CLAIM OF PROPERTY DAMAGE

DEPARTMENT OF HEALTH AND HUMAN SERVICES
FOSTER CARE
SFN 327 (9-2023)

Clear Fields

Use of form: Completion of this form is required when a child in foster care damages property. This form is to be completed by the foster parent, in its entirety, and submitted by the custodial case manager within 90 days of the discovery of the property damage. If approved, payment will be made to the party experiencing the damage.

Name of Foster Care Provider			Provider Number	
Mailing Address		City	State	ZIP Code
Telephone Number	Email Address			

Authorized Licensing Agent ☐ HHS - CFS Licensing ☐ Nexus PATH ☐ Tribal Nation ☐ Unaccompanied Refugee Minor (URM)	
Licensing Specialist Name	Custodial Case Manager Name
Is the licensor aware of the damage? ☐ Yes ☐ No	Is the child's case manager aware of the damage? ☐ Yes ☐ No

Name of Person Who Experienced Property Damage (if different than the licensed foster parent named above)			
Mailing Address	City	State	ZIP Code
Telephone Number	Email Address		

List the name, date of placement, and date of birth of each foster child who caused the damage.

NAME	DATES OF PLACEMENT	DATE OF BIRTH
Date of Damage	If damage occurred over a period of time, list beginning and end dates. From: To:	
Will payment be made from a private insurer? ☐ Yes ☐ No	If Yes, Payment Amount/Deductible	

Attach documentation from insurance company which verifies payment or denial, and amount of deductible paid by affected party. If the deductible for homeowner's insurance is greater than the cost of the damage, submit proof of deductible amount.

I hereby certify that all statements and information provided are true and correct to the best of my ability and that the damage claimed actually occurred. I understand that the placing agency or representatives of the Department of Health and Human Services will verify this claim and may contact any parties involved. I understand that I may only claim for damage not covered by any other insurance.

Signature - Foster Care Provider	Date Signed

STATEMENT OF CIRCUMSTANCES FOR DAMAGE

Describe the details surrounding the damage (who, what, where, when).
Include the names of any witnesses to the occurrence. Attach photographs of damages.

ITEMIZATION OF DAMAGE

List each item, the date damage occurred, and the replacement/repair cost for which you are submitting a claim. If you need more space, continue on a separate sheet of paper using the same format. Sales receipts, a bill or an estimate for each item listed must be attached.

Item	Damage Date	Replacement/Repair Cost
	Total Cost of Property Damage	
	- Insurance Payment	
	- HHS Deductible	$100.00
	= Amount of Claim	

FOR DEPARTMENT OF HEALTH AND HUMAN SERVICE USE ONLY

A. Department Verification

1. Date SFN-327 was received by the Department:		
2. Was foster care provider licensed at the time of property damage?	☐ Yes	☐ No
3. Was child in foster care placed in the home at the time of property damage?	☐ Yes	☐ No
4. Were photos of the damage submitted to the department?	☐ Yes	☐ No
5. Was verification from case manager regarding the incident received?	☐ Yes	☐ No
6. Has a claim regarding this incident been submitted to the private insurer of the person experiencing the property damage?	☐ Yes	☐ No
7. Is there documentation of insurance coverage or insurance denial provided?	☐ Yes	☐ No
8. Is there documentation of the amount of applicable deductible?	☐ Yes	☐ No
9. Have the estimate by a contractor or insurance adjuster, bill, or receipt of payment for each item lost or damaged been provided?	☐ Yes	☐ No
10. Has foster parent filed any claims to the Department since last July 1?	☐ Yes	☐ No

If "Yes", list date and amount of each claim.

Date	Amount of Claim

B. Department Payment Approval

☐ Pay Amount Claimed

Amount Claimed:	
Less HHS Deductible:	$100.00
Recommended Payment:	($100.00)

☐ Pay Amount Other Than Claimed

Amount Claimed:	
Less HHS Deductible:	$100.00
Recommended Payment:	($100.00)

☐ Disregard Claim

If amount other than claimed is to be paid or claim is to be disregarded, provide explanation of recommendation:

Signature of CFS Administrator or Designee	Date Signed
Signature of CFO, Fiscal Administration or Designee	Date Signed
Signature of Risk Manager, Executive Office, or Designee	Date Signed