Department of Administrative Services
Guidance Document

This guidance document is advisory in nature but is binding on an agency until amended by such agency. A guidance document does not include internal procedural documents that only affect the internal operations of the agency and does not impose additional requirements or penalties on regulated parties or include confidential information or rules and regulations made in accordance with the Administrative Procedure Act. If you believe that this guidance document imposes additional requirements or penalties on regulated parties, you may request a review of the document.

State of Nebraska Foster Care Claim Form

This form is for Foster Parents involved in the Foster Care Program through the Nebraska Department of Health and Human Services.

Only **COMPLETED** and **SIGNED** Claim Forms will be accepted by the Office of Risk Management.

* Indicates a **REQUIRED** field. If required fields are not filled out, your Claim will not be processed.

FOR OFFICE USE ONLY

Claimant's Name*:	Claimant's Phone Number*:	Alternate Phone Number:
Claimant's Mailing Address*:	Claimant's Email Address:	Date of Occurrence*:
	Case Manager's Name*:	Case Manager's Phone Number*:

Foster Child(ren) Names(s) *:

Do you have insurance covering this claim? ☐ YES ☐ NO	Insurance Deductible Amount:
If YES, have you filed a claim with your Insurer? ☐ YES ☐ NO	Date Claim Filed:
Has your Insurer made a determination? ☐ YES ☐ NO	If YES, attach a copy of the determination letter.
Has your Insurer made any payments? ☐ YES ☐ NO	If YES, amount:
Has any other Insurance Company made payments? ☐ YES ☐ NO	If YES, amount:

Name and Address of Insurance Company & Insurance Policy Number:

Name, Address, and Phone Number of Attorney, if any:

In the below space, please provide a detailed itemization of all known facts/circumstances/damages leading to your claim. Identify all property, places, and people involved. Include names, addresses, and phone numbers of witnesses, if any. The information provided below, along with the findings of the investigating agency, will form the basis of any decision.*

If additional space is needed, please use another page.

Claimant Signature*:	Date*:

Under Penalties of law, I declare that I have examined this statement and that it is, to the best of my knowledge and belief, true, complete, and correct, and that I am duly authorized to sign this statement.

Please include copies of any supporting documents that may be relevant to your claim including, but not limited to, Photos, Invoices, Receipts, Police Reports, Estimates, Medical Bills, Expense Reports, etc.

Make and keep copies of all documentation submitted as copies will not be provided.

Claim form and supporting documents should be emailed to: as.riskmanagement@nebraska.gov
If you are unable to submit your claim by email, you may mail your claim to:
Office of Risk Management, PO Box 94974, Lincoln, NE 68509-4974
****DO NOT SUBMIT YOUR CLAIM MORE THAN ONCE****
Questions? Call the Office of Risk Management at (402) 471-2551

NEBRASKA
Good Life. Great Service.
DEPT. OF ADMINISTRATIVE SERVICES
Risk Management