



Foster Parent Claim Form
NEBRASKA DEPARTMENT OF HEALTH & HUMAN SERVICES

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|---|---------------------------|---------------------------------|
| 1. Name | 2. Social Security Number | 3. E-mail Address |
| 4. Street Address | 5. City, State, Zip Code | 6. Phone Number |
| 7. Place of Occurrence – City / County | | 8. Date of Occurrence |
| 9. Foster Child(ren) Names(s) | | |
| 10. Case Manager's Name | | 11. Case Manager's Phone Number |
| 12. Do You Have Insurance Covering This Claim <input type="checkbox"/> YES <input type="checkbox"/> NO | | 13. Deductible \$ |
| 14. If yes, please attached a copy of the determination letter. Or, if any other insurance company has made payment, please state amount. | | 15. Amount Paid To You \$ |
| 16. Have You Filed A Claim With Your Homeowner's and/or Automobile Insurance <input type="checkbox"/> YES <input type="checkbox"/> NO | | |
| 17. Name, Address and Phone Number of Your Insurance Company and Insurance Policy Number | | |
| 18. Name, Address, and Phone Number of Your Attorney, if any | | |
| 19. Description of Accident or Occurrence. | | |

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.

sign here _____
(Claimant's Signature)

Please retain a copy of your claim form and documentation for your files and mail the original signed claim form to:

NRMA
Centerstone Building
100 North 12th Street, Ste 200
Lincoln, NE 68508
402-742-9220