



KINSHIP REIMBURSEMENT PAYMENT APPLICATION

Purpose: The Relative and Other Designated Caregiver Program helps kinship caregivers with the cost of caring for a child who is, or has been, in DFPS conservatorship. As part of the program, a kinship caregiver who received permanent managing conservatorship (PMC) of a child through DFPS may receive annual reimbursement of up to \$500 per child for child-related expenses. See below for eligibility requirements. Use this form to apply for reimbursement.

Directions: Complete one form for each child.

Eligibility for Annual Reimbursement: You can request reimbursement beginning on the one year anniversary of the a date you received PMC of the child. The annual reimbursement is available for eligible expenses that occur after September 1, 2005, if:

- the placement was formally approved by DFPS and the child remains in your home;
- you have signed the Kinship Caregiver Agreement;
- no other caregiver has been paid under this provision on behalf of this child or sibling group;
- the placement is not a licensed or verified foster or group home; and
- your family income does not exceed 300% of the federal poverty level (based on gross annual income).

Note: If permanent managing conservatorship (PMC) was transferred to you after September 1, 2005, and you are not in the Permanency Care Assistance, or PCA, program, you may request reimbursement for 3 years after the transfer or until the child reaches age 18, whichever comes first. You must also meet all other eligibility requirements and restrictions. If you have PMC of the child, you must attach a copy of a document (school records, day care records, Medicaid card, etc.) that confirms the child lives with you. You may be asked for the PMC court order if the child's residency cannot be verified.

CAREGIVER INFORMATION		
	<input type="checkbox"/> Post-PMC Reimbursement	
Last Name:	First Name:	
Relation to Child:	Social Security Number:	Phone Number:
Address:		
Number in Household (all household except boarders):		
Annual (Gross) Income (all sources for all adults in the family except boarders):		
INFORMATION ON THE CHILD FOR WHOM MONEY WAS SPENT		
Last Name:	First Name:	
Date of Birth:		
Date Caregiver Received PMC:		
VERIFICATION		
Does the child remain in your care? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Select and attach one of the following documents as proof of child's residency (only one document is necessary): <input type="checkbox"/> Child's School Records <input type="checkbox"/> Child's Texas ID <input type="checkbox"/> Child's Medicaid Card <input type="checkbox"/> Other		
Has another caregiver been paid under this provision on behalf of this child (worker must verify before processing)? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Have you legally adopted this child? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Are you receiving Permanency Care Assistance for this child? <input type="checkbox"/> Yes <input type="checkbox"/> No		

TIME PERIOD COVERING THE BELOW EXPENSES

BEGIN DATE _____ **END DATE** _____

ITEMS/SERVICES PURCHASED

Item/Service	Cost
<input type="checkbox"/> Clothing/shoes	\$
<input type="checkbox"/> School supplies	\$
<input type="checkbox"/> Bed/crib, bed linens	\$
<input type="checkbox"/> High chair, stroller	\$
<input type="checkbox"/> Health items (such as vitamins, medications not covered by insurance)	\$
<input type="checkbox"/> Tutoring	\$
<input type="checkbox"/> Course fees (such as driving, summer school, college applications)	\$
<input type="checkbox"/> Club dues and expenses (such as scouts, school clubs)	\$
<input type="checkbox"/> Activity expenses (such as sports, dance lessons)	\$
<input type="checkbox"/> School ring, prom clothing	\$
<input type="checkbox"/> Camp fees and supplies	\$
<input type="checkbox"/> Car insurance (teen)	\$
<input type="checkbox"/> Other (specify)	\$

What is the time period covering the above expenses? Begin date: _____ End date: _____

SIGNATURE

I certify that the information above is complete, true, and correct to the best of my knowledge. I understand that lack of full, true, and complete disclosure may be grounds for withholding payment and may cause termination of the application.

Relative or Other Designated Caregiver: X	Date Signed:
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