

## Kinship Care Payment Application

**Use of form:** Use of this form is mandatory; its completion meets the requirements of s.48.57(3m) of the Wisconsin Statutes and Ch. DCF 58.04 Admin. Code. Personal identifiable information collected on this form is confidential and will be used for identification and determination of eligibility for a payment only. Personal information you provide may be used for secondary purposes [Privacy Law, s.15.04(1)(m), Wisconsin Statutes]. Provision of your social security number (SSN) is voluntary; not providing it will result in an information processing delay and possible effect eligibility determination.

**NOTICE:** This form must be completed to the best of the applicant's ability. Misrepresenting the applicant's relationship to the child, or providing false information regarding the child, the child's parents, the applicant or members of the applicant's household will result in denial of the kinship grant.

### I. CHILD IN PROVIDER'S CARE REQUESTING KINSHIP CARE

<b>Name – Child 1</b> (Last, First, MI)		Birthdate	Social Security Number or date applied
<input type="checkbox"/> Yes <input type="checkbox"/> No Does the child receive social security income (SSI) on his or her <b>own</b> behalf? If "Yes", he or she is ineligible for Kinship Care payment.		Last Grade Completed	
<input type="checkbox"/> Yes <input type="checkbox"/> No U.S Citizen	If the child is not a U.S. citizen, describe status:		Name of School
<input type="checkbox"/> Yes <input type="checkbox"/> No Do you have guardianship of this child?		Type of Guardianship <input type="checkbox"/> s. 48.977 Wis. Stats. <input type="checkbox"/> s. 48.9795 Wis. Stats (includes Ch. 54) <input type="checkbox"/> Other, please describe:	
Ethnicity (Check at least one box and may check up to three boxes)			
<input type="checkbox"/> White		<input type="checkbox"/> Asian	
<input type="checkbox"/> Black / African American		<input type="checkbox"/> Native Hawaiian / Pacific Islander	
<input type="checkbox"/> American Indian / Alaskan Native		<input type="checkbox"/> Other	
<input type="checkbox"/> Yes <input type="checkbox"/> No Does the child have health insurance?		If yes, type: <input type="checkbox"/> Badgercare+ <input type="checkbox"/> Private Health Insurance	
Relationship to caregiver		Date began living with caregiver	

Describe why the child cannot live with their parent(s):

<b>Name – Parent 1</b> of Minor Relative		Social Security Number	Birthdate	Telephone Number – Home
Address – Street		City	State	Zip Code
Ethnic / Racial Group (Check one)			Marital Status	
<input type="checkbox"/> Black (not of Hispanic origin)		<input type="checkbox"/> American Indian / Alaskan Native		<input type="checkbox"/> White
<input type="checkbox"/> Asian or Pacific Islander		<input type="checkbox"/> Hispanic (Mexican, Puerto Rican or other Spanish culture)		<input type="checkbox"/> Married <input type="checkbox"/> Never Married <input type="checkbox"/> Separated <input type="checkbox"/> Unknown <input type="checkbox"/> Divorced
Employed? <input type="checkbox"/> Yes <input type="checkbox"/> No	Name – Employer			
Address - Employer (Street, City, State, Zip Code)				Telephone Number

Wages Earned \$ _____	Wages Paid <input type="checkbox"/> Weekly <input type="checkbox"/> Biweekly <input type="checkbox"/> 2 x Month <input type="checkbox"/> Monthly <input type="checkbox"/> Other - _____
--------------------------	--

Unearned Income

Unemployment insurance - \$ \_\_\_\_\_ per \_\_\_\_\_   
 SSI - \$ \_\_\_\_\_  
 SS Retirement - \$ \_\_\_\_\_ per month   
 SS Disability Insurance - \$ \_\_\_\_\_  
 Veteran's benefits - \$ \_\_\_\_\_ per month   
 Other income - \$ \_\_\_\_\_ per \_\_\_\_\_

Name – Parent 2 of Minor Relative	Social Security Number	Birthdate	Telephone Number – Home
Address – Street	City	State	Zip Code

Ethnic / Racial Group (Check one) <input type="checkbox"/> Black (not of Hispanic origin) <input type="checkbox"/> American Indian / Alaskan Native <input type="checkbox"/> White <input type="checkbox"/> Asian or Pacific Islander <input type="checkbox"/> Hispanic (Mexican, Puerto Rican or other Spanish culture) (includes Indian Subcontinent origin)	Marital Status <input type="checkbox"/> Married <input type="checkbox"/> Never Married <input type="checkbox"/> Separated <input type="checkbox"/> Unknown <input type="checkbox"/> Divorced
---	---

Employed? <input type="checkbox"/> Yes <input type="checkbox"/> No	Name – Employer	
Address - Employer (Street, City, State, Zip Code)		Telephone Number

Wages Earned \$ _____	Wages Paid <input type="checkbox"/> Weekly <input type="checkbox"/> Biweekly <input type="checkbox"/> 2 x Month <input type="checkbox"/> Monthly <input type="checkbox"/> Other - _____
--------------------------	--

Unearned Income

Unemployment insurance - \$ \_\_\_\_\_ per \_\_\_\_\_   
 SSI - \$ \_\_\_\_\_  
 SS Retirement - \$ \_\_\_\_\_ per month   
 SS Disability Insurance - \$ \_\_\_\_\_  
 Veteran's benefits - \$ \_\_\_\_\_ per month   
 Other income - \$ \_\_\_\_\_ per \_\_\_\_\_

Name – Child 2 (Last, First, MI)	Birthdate	Social Security Number or date applied
----------------------------------	-----------	--

<input type="checkbox"/> Yes <input type="checkbox"/> No Does the child receive social security income (SSI) on his or her <b>own</b> behalf? If “Yes”, he or she is ineligible for Kinship Care payment.	Last Grade Completed
--	----------------------

<input type="checkbox"/> Yes <input type="checkbox"/> No U.S Citizen	If the child is not a U.S. citizen, describe status:	Name of School
--	--	----------------

<input type="checkbox"/> Yes <input type="checkbox"/> No Do you have guardianship of this child?	Type of Guardianship <input type="checkbox"/> s. 48.977 Wis. Stats. <input type="checkbox"/> s. 48.9795 or Ch. 54 <input type="checkbox"/> Other, please describe:
--	--

Ethnicity (Check at least one box and may check up to three boxes)

<input type="checkbox"/> White	<input type="checkbox"/> Asian
<input type="checkbox"/> Black / African American	<input type="checkbox"/> Native Hawaiian / Pacific Islander
<input type="checkbox"/> American Indian / Alaskan Native	<input type="checkbox"/> Other

<input type="checkbox"/> Yes <input type="checkbox"/> No Does the child have health insurance?	If yes, type: <input type="checkbox"/> Badgercare+ <input type="checkbox"/> Private Health Insurance
Relationship to caregiver	Date began living with caregiver

Describe why the child cannot live with their parent(s):

Name – Parent 1 of Minor Relative		Social Security Number	Birthdate	Telephone Number – Home
Address – Street		City	State	Zip Code
Ethnic / Racial Group (Check one) <input type="checkbox"/> Black (not of Hispanic origin) <input type="checkbox"/> American Indian / Alaskan Native <input type="checkbox"/> White <input type="checkbox"/> Asian or Pacific Islander <input type="checkbox"/> Hispanic (Mexican, Puerto Rican or (includes Indian Subcontinent origin) other Spanish culture)			Marital Status <input type="checkbox"/> Married <input type="checkbox"/> Never Married <input type="checkbox"/> Separated <input type="checkbox"/> Unknown <input type="checkbox"/> Divorced	
Employed? <input type="checkbox"/> Yes <input type="checkbox"/> No	Name – Employer			
Address - Employer (Street, City, State, Zip Code)			Telephone Number	
Wages Earned \$	Wages Paid <input type="checkbox"/> Weekly <input type="checkbox"/> Biweekly <input type="checkbox"/> 2 x Month <input type="checkbox"/> Monthly <input type="checkbox"/> Other - _____			
Unearned Income <input type="checkbox"/> Unemployment insurance - \$ _____ per _____ <input type="checkbox"/> SSI - \$ _____ <input type="checkbox"/> SS Retirement - \$ _____ per month <input type="checkbox"/> SS Disability Insurance - \$ _____ <input type="checkbox"/> Veteran's benefits - \$ _____ per month <input type="checkbox"/> Other income - \$ _____ per _____				

Name – Parent 2 of Minor Relative		Social Security Number	Birthdate	Telephone Number – Home
Address – Street		City	State	Zip Code
Ethnic / Racial Group (Check one) <input type="checkbox"/> Black (not of Hispanic origin) <input type="checkbox"/> American Indian / Alaskan Native <input type="checkbox"/> White <input type="checkbox"/> Asian or Pacific Islander <input type="checkbox"/> Hispanic (Mexican, Puerto Rican or (includes Indian Subcontinent origin) other Spanish culture)			Marital Status <input type="checkbox"/> Married <input type="checkbox"/> Never Married <input type="checkbox"/> Separated <input type="checkbox"/> Unknown <input type="checkbox"/> Divorced	
Employed? <input type="checkbox"/> Yes <input type="checkbox"/> No	Name – Employer			
Address - Employer (Street, City, State, Zip Code)			Telephone Number	
Wages Earned \$	Wages Paid <input type="checkbox"/> Weekly <input type="checkbox"/> Biweekly <input type="checkbox"/> 2 x Month <input type="checkbox"/> Monthly <input type="checkbox"/> Other - _____			
Unearned Income <input type="checkbox"/> Unemployment insurance - \$ _____ per _____ <input type="checkbox"/> SSI - \$ _____ <input type="checkbox"/> SS Retirement - \$ _____ per month <input type="checkbox"/> SS Disability Insurance - \$ _____ <input type="checkbox"/> Veteran's benefits - \$ _____ per month <input type="checkbox"/> Other income - \$ _____ per _____				

**II. RELATIVE CAREGIVER(S)**

**DCF Ch. 58.02(2)** Relative" means an adult who is the child's stepparent, brother, sister, stepbrother, stepsister, half-brother, half-sister, brother-in-law, sister-in-law, first cousin, 2nd cousin, nephew, niece, aunt, uncle, step uncle, step aunt, or any person of a preceding generation as denoted by the prefix of grand, great or great-great, whether by blood,

marriage or legal adoption, or the spouse of any person named in this subsection, even if the marriage is terminated by death or divorce.

<b>CAREGIVER 1</b> Name (Last, First, MI)	Social Security Number	<input type="checkbox"/> Yes <input type="checkbox"/> No Are you a Wisconsin resident? If "Yes", for how long?
---	------------------------	---

Telephone Number – Home	Telephone Number – Work	Telephone Number – Cell
-------------------------	-------------------------	-------------------------

Email Address	Driver’s License Number and State of Issuance
---------------	---

<input type="checkbox"/> Yes <input type="checkbox"/> No Are you a relative of the child? If “Yes”, check applicable box below:	Check box for which side of the child’s family you are related through <input type="checkbox"/> Maternal <input type="checkbox"/> Paternal
---	---

<input type="checkbox"/> Step-parent	<input type="checkbox"/> Brother	<input type="checkbox"/> Sister	<input type="checkbox"/> Stepsister
<input type="checkbox"/> Stepbrother	<input type="checkbox"/> Half-brother	<input type="checkbox"/> Half-sister	<input type="checkbox"/> brother-in-law
<input type="checkbox"/> Sister- in-law	<input type="checkbox"/> First Cousin	<input type="checkbox"/> Second Cousin	<input type="checkbox"/> Nephew
<input type="checkbox"/> Niece	<input type="checkbox"/> Aunt	<input type="checkbox"/> Uncle	<input type="checkbox"/> Step-uncle
<input type="checkbox"/> Step-aunt	<input type="checkbox"/> Grandfather	<input type="checkbox"/> Grandmother	<input type="checkbox"/> Great-grandfather
<input type="checkbox"/> Great-grandmother	<input type="checkbox"/> Great-uncle	<input type="checkbox"/> Great-aunt	<input type="checkbox"/> Great-great-aunt
<input type="checkbox"/> Great-great-uncle	<input type="checkbox"/> Great-great grandfather	<input type="checkbox"/> Great-great step uncle	<input type="checkbox"/> Great-great step aunt

Current Address – Street	City	State	Zip Code
--------------------------	------	-------	----------

School District of the Caregiver’s Residence

Mailing Address if Different Than Above

Previous Addresses for Last 5 Years (Including Out-of-State or Country)

Address – Street	City	State	Zip Code
Address – Street	City	State	Zip Code
Address – Street	City	State	Zip Code
Address – Street	City	State	Zip Code
Address – Street	City	State	Zip Code

Demographic Information of Relative Caregiver Applicant

Birthdate	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Social Security Number	<input type="checkbox"/> Yes <input type="checkbox"/> No Hispanic or Latino / Latina
-----------	---	------------------------	---

Ethnicity (Check at least one box and may check up to three boxes) <input type="checkbox"/> White <input type="checkbox"/> Asian <input type="checkbox"/> Black / African American <input type="checkbox"/> Native Hawaiian / Pacific Islander <input type="checkbox"/> American Indian / Alaskan Native <input type="checkbox"/> Other	<input type="checkbox"/> Yes <input type="checkbox"/> No U.S Citizen?
--	---

Birthplace	Weight	Height	Hair Color	Eye Color
------------	--------	--------	------------	-----------

Marital Status

<input type="checkbox"/> Single – never married	<input type="checkbox"/> Divorced
<input type="checkbox"/> Married – living together	<input type="checkbox"/> Widowed
<input type="checkbox"/> Married – but separated	

**Educational Level**

Enter highest level of education attained.

- 01 to 11 Grade level completed in primary / secondary school. Enter last grade completed.
- 12 High school diploma, GED or National External Diploma Program
- 13 Awarded associate degree
- 14 Awarded Bachelor's Degree
- 15 Awarded Graduate Degree (Master's or higher)
- 16 Other credentials (degree, certificate, diploma, etc.)
- 98 No formal education

**Current Employment Status**

Employed    Unemployed    Not in labor force (not looking for work, retired, disabled, etc.)

<b>CAREGIVER 2</b> Name (Last, First, MI)	Social Security Number	<input type="checkbox"/> Yes <input type="checkbox"/> No   Are you a Wisconsin resident? If "Yes", for how long?
---	------------------------	---

Telephone Number – Home	Telephone Number – Work	Telephone Number – Cell
-------------------------	-------------------------	-------------------------

Email Address	Driver's License Number and State
---------------	-----------------------------------

<input type="checkbox"/> Yes <input type="checkbox"/> No   Are you a relative of the child? If "Yes", check applicable box below:	Check box for which side of the child's family <input type="checkbox"/> Maternal <input type="checkbox"/> Paternal
---	---

<input type="checkbox"/> Stepparent	<input type="checkbox"/> Brother	<input type="checkbox"/> Sister	<input type="checkbox"/> Stepsister
<input type="checkbox"/> Stepbrother	<input type="checkbox"/> Half-brother	<input type="checkbox"/> Half-sister	<input type="checkbox"/> brother-in-law
<input type="checkbox"/> sister- in-law	<input type="checkbox"/> First Cousin	<input type="checkbox"/> Second Cousin	<input type="checkbox"/> Nephew
<input type="checkbox"/> Niece	<input type="checkbox"/> Aunt	<input type="checkbox"/> Uncle	<input type="checkbox"/> Step-uncle
<input type="checkbox"/> Step-aunt	<input type="checkbox"/> Grandfather	<input type="checkbox"/> Grandmother	<input type="checkbox"/> Great-grandfather
<input type="checkbox"/> Great-grandmother	<input type="checkbox"/> Great-uncle	<input type="checkbox"/> Great-aunt	<input type="checkbox"/> Great-great-aunt
<input type="checkbox"/> Great-great-uncle			

Current Address – Street	City	State	Zip Code
--------------------------	------	-------	----------

**Mailing Address if Different Than Above**

**Previous Addresses for Last 5 Years (Including Out-of-State or Country)**

Address – Street	City	State	Zip Code
Address – Street	City	State	Zip Code
Address – Street	City	State	Zip Code
Address – Street	City	State	Zip Code
Address – Street	City	State	Zip Code

**Demographic Information of Relative Caregiver Applicant**

Birthdate	Gender	Social Security Number	<input type="checkbox"/> Yes <input type="checkbox"/> No   Hispanic or Latino / Latina
-----------	--------	------------------------	---

<input type="checkbox"/> Male <input type="checkbox"/> Female			
Ethnicity (Check at least one box and may check up to three boxes) <input type="checkbox"/> White <input type="checkbox"/> Asian <input type="checkbox"/> Black / African American <input type="checkbox"/> Native Hawaiian / Pacific Islander <input type="checkbox"/> American Indian / Alaskan Native <input type="checkbox"/> Other			<input type="checkbox"/> Yes <input type="checkbox"/> No U.S Citizen?

**Marital Status**

- Single – never married  Divorced  
 Married – living together  Widowed  
 Married – but separated

Birthplace	Weight	Height	Hair Color	Eye Color
------------	--------	--------	------------	-----------

**Educational Level**

Enter highest level of education attained

- 01 to 11 Grade level completed in primary / secondary school. Enter last grade completed.
- 12 High school diploma, GED or National External Diploma Program
- 13 Awarded Associate's Degree
- 14 Awarded Bachelor's Degree
- 15 Awarded Graduate Degree (Master's or higher)
- 16 Other credentials (degree, certificate, diploma, etc.)
- 98 No formal education

**Current Employment Status**

- Employed  Unemployed  Not in labor force (not looking for work, retired, disabled, etc.)

**III. OTHER ADULT MEMBERS IN THE HOUSEHOLD**

1. Name (Last, First, MI)		Social Security Number	Birthdate (mm/dd/yyyy)
Relationship to Relative Caregiver	<input type="checkbox"/> Yes <input type="checkbox"/> No Wisconsin resident? If "Yes", for how long?		
2. Name (Last, First, MI)		Social Security Number	Birthdate (mm/dd/yyyy)
Relationship to Relative Caregiver	<input type="checkbox"/> Yes <input type="checkbox"/> No Wisconsin resident? If "Yes", for how long?		
3. Name (Last, First, MI)		Social Security Number	Birthdate (mm/dd/yyyy)
Relationship to Relative Caregiver	<input type="checkbox"/> Yes <input type="checkbox"/> No Wisconsin resident? If "Yes", for how long?		
4. Name (Last, First, MI)		Social Security Number	Birthdate (mm/dd/yyyy)
Relationship to Relative Caregiver	<input type="checkbox"/> Yes <input type="checkbox"/> No Wisconsin resident? If "Yes", for how long?		
5. Name (Last, First, MI)		Social Security Number	Birthdate (mm/dd/yyyy)
Relationship to Relative Caregiver	<input type="checkbox"/> Yes <input type="checkbox"/> No Wisconsin resident? If "Yes", for how long?		

Narrative

**IV. OTHER CHILDREN IN THE HOUSEHOLD**

1. Name (Last, First, MI)		Birthdate (mm/dd/yyyy)	
Relationship to Relative Caregiver	<input type="checkbox"/> Yes <input type="checkbox"/> No Wisconsin resident? If "Yes", for how long?		
2. Name (Last, First, MI)		Birthdate (mm/dd/yyyy)	
Relationship to Relative Caregiver	<input type="checkbox"/> Yes <input type="checkbox"/> No Wisconsin resident? If "Yes", for how long?		
3. Name (Last, First, MI)		Birthdate (mm/dd/yyyy)	
Relationship to Relative Caregiver	<input type="checkbox"/> Yes <input type="checkbox"/> No Wisconsin resident? If "Yes", for how long?		
4. Name (Last, First, MI)		Birthdate (mm/dd/yyyy)	
Relationship to Relative Caregiver	<input type="checkbox"/> Yes <input type="checkbox"/> No Wisconsin resident? If "Yes", for how long?		
5. Name (Last, First, MI)		Birthdate (mm/dd/yyyy)	
Relationship to Relative Caregiver	<input type="checkbox"/> Yes <input type="checkbox"/> No Wisconsin resident? If "Yes", for how long?		

Narrative

**V. EMPLOYEES OF CAREGIVER RELATIVE WHO WOULD HAVE REGULAR CONTACT WITH CHILD**

1. Name		Birthdate (mm/dd/yyyy)		Telephone Number – Home	
Address – Street		City		State	Zip Code
<input type="checkbox"/> Yes <input type="checkbox"/> No Wisconsin resident? If "Yes", for how long?					
2. Name		Birthdate (mm/dd/yyyy)		Telephone Number – Home	
Address – Street		City		State	Zip Code
<input type="checkbox"/> Yes <input type="checkbox"/> No Wisconsin resident? If "Yes", for how long?					
3. Name		Birthdate (mm/dd/yyyy)		Telephone Number – Home	
Address – Street		City		State	Zip Code
<input type="checkbox"/> Yes <input type="checkbox"/> No Wisconsin resident? If "Yes", for how long?					

**VI. KINSHIP CARE REFERRAL FOR CHILD SUPPORT SERVICES -DCF 58.04(2)(e)**

**CURRENT RELATIONSHIP OF CHILD'S PARENTS TO EACH OTHER**

Relationship Status

- Married                       Divorced                       Separated with court order  
 Never married               Unknown                       Separated without court order

Date - If Ever Married (mm/dd/yyyy)

Place of Marriage (City, State)

Child Support Order Currently in Effect?

- Yes  No  Unknown

Child Support Amount (If applicable)

\$ \_\_\_\_\_ per \_\_\_\_\_

Child Support Being Paid

- Yes - Regularly     No  
 Yes - Irregularly    Unknown

Paternity Established

- Yes  No  Unknown

Who is responsible for the case?

County  
State  
Tribe

Order for Medical Support in Effect?

- Yes     No     Unknown

Child Receiving Medical Assistance (MA)?

- Yes  No  Unknown    If "Yes", provide the MA number (if known) \_\_\_\_\_

**VII. KINSHIP CARE GOOD CAUSE NOTICE-DCF 58.12(2)**

**Cooperation with Child Support means that you may have to do one or more of the following things:**

1. Name the parent(s) of any child included in your application for Kinship Care and give information to help find the parent(s).
2. Help to obtain money owed to the child(ren) who receive Kinship Care.
3. Help to obtain any other money or property due to any child included in your application for Kinship Care.
4. Report to the child welfare agency any court-ordered or voluntary child support paid directly to you by the non-custodial parent(s).
5. You may have to go to either the child welfare agency or the child support agency to sign necessary papers or give necessary information.

**Your cooperation with Child Support is important because it would help entitle the child(ren) in your care to:**

1. Know who are the child's legally recognized parents.
2. Receive emotional and financial support from both parents.
3. Receive social security, pension, and inheritance rights from both parents.
4. Receive adequate medical support and family medical histories from both parents.

Despite these possible benefits, you may have a good reason for not cooperating. Such a reason is called "good cause." If you believe that cooperating would cause you or the child(ren) in your care serious physical or emotional harm or create other situations you think would be harmful, you may have "good cause" now or at any time in the future. If you do claim "good cause," you must provide supporting evidence as to why you should not be required to cooperate.

If you want to claim "good cause" for not cooperating, complete the next section of this form.

If you want to claim "good cause" for not cooperating, but the child welfare agency does not approve your claim, you will not be eligible for Kinship Care unless you begin to cooperate. If you do not agree with the "good cause" claim decision, you may be able to request an appeal of that decision. The worker determining the Kinship Care eligibility will be able to provide you with more information.



**Leave this Section blank if you are not requesting Good Cause**

**VIII. KINSHIP CARE GOOD CAUSE CLAIM- DCF 58.12**

**For Refusing to Cooperate in Obtaining Child and / or Medical Support**

The following are circumstances under which the county or tribal child welfare agency may find that you have “good cause” for not cooperating:

1. Your cooperation could result in physical or emotional harm to the child in your care.
2. Your cooperation could result in physical or emotional harm to you which is so serious it reduces your ability to care for the child adequately.
3. The child in your care was born as a result of incest or sexual assault.

If you claim “good cause” for one of the above reasons, you must provide evidence to support your claim. You have 20 days from the date you claim “good cause” to give the child welfare agency this evidence. More time can be approved for exceptional reasons. The following are examples of the kinds of evidence you can use to support “good cause.”

1. Birth certificates or medical or law enforcement records that indicate that the child was conceived as the result of incest or sexual assault.
2. Court, medical, criminal, child protective services, social services, psychological or law enforcement records which indicate that the alleged or absent parent might inflict physical or emotional harm on you or the child.
3. Medical records which give your or the child’s emotional health history and present health status; or written statements from a mental health professional indicating a diagnosis or prognosis concerning the emotional health of you or the child.
4. A sworn statement from individuals, including friends, neighbors, clergy, social workers and medical professionals who might have knowledge of circumstances which would help support your claim.
5. Any other supporting or corroborative evidence.

If you have no evidence to support your fear of physical harm, it may still be able to make a "good cause" determination after an investigation. The agency may decide to conduct an investigation of any good cause claim. You may be required to give information to help in that investigation. The absent parent(s) will not be contacted without your being told first. The child welfare agency must decide within 45 days if you have “good cause” based on your evidence.

Kinship Care payments cannot be denied, delayed, reduced or discontinued pending a determination of "good cause." You will be notified immediately of the agency’s “good cause” determination. If “good cause” is not found, you will have 10 days to withdraw the claim and cooperate, withdraw your application or request that your case be closed, exclude allowable individuals from the application or case, or request any allowable appeal.

If you are found to have “good cause” for not cooperating, the child support agency will be notified of the decision and directed to:

1. Take no further action to establish paternity, collect child support or pursue third parties who may be liable for medical support; or
2. Attempt to establish paternity, collect child support, or pursue third parties who may be liable for medical support without your cooperation, if this can be done without risk to you or the child.

If you do not sign this official claim for “good cause” in the presence of the agency worker, you must have your signature notarized. Deliver this notice to the agency in person or send it by registered or certified mail.

If your evidence is not sufficient, the Kinship Care agency will tell you what other evidence is needed. They will give you reasonable help in obtaining the necessary evidence.

I certify that my “good cause” claim is based on fact to the best of my knowledge. I understand that giving false information will cause this

claim to be denied. I have received a copy of this claim. I hereby claim “good cause” for the following reasons:

\_\_\_\_\_  
**SIGNATURE** - Relative Caregiver / Applicant

\_\_\_\_\_  
Date Signed

\_\_\_\_\_  
Name- Child Welfare Agency

\_\_\_\_\_  
Date Signed

---

**VIV. CONFIRMATION**

---

I, the undersigned Caregiver, attest to the following:

- Neither I, any other adult resident of this household nor any employee who would have regular contact with the minor relative identified in this application, have any arrests or convictions which would adversely affect the minor relative or my ability to care for the minor relative identified in this application.
- I attest that the child(ren) reside in my home.
- I attest the I am related to child(ren) per Ch.58.02(20).
- I will assist the agency to the extent possible in referring the parents of the minor relative identified above to the child support agency or I have requested a Good Cause claim.
- I will cooperate with the agency in this application process, the annual eligibility redetermination, including applying for any other financial assistance programs for which the minor relative identified above may be eligible.
- I understand that the Kinship Care funds I receive may not be used toward purchases in any liquor store; any casino, gambling casino, or gaming establishment; or any retail establishment which provides adult-oriented entertainment in which performers disrobe or perform in an unclothed state for entertainment.
- I will notify the agency within five (days) of any of the following occurring:
  - The habitation of any other adult in my home and prior to employment of any person who would have regular contact with the minor relative in this application.
  - The child and I move to a new residence.
  - I, or a prospective employee, employee, prospective adult resident, or adult resident of my home is the subject an investigation or final substantiated finding that the person has abused or neglected a child.
  - The child has a new caregiver.
  - The child is no longer living with me.
  - The child is married.
  - The child entered the military.
  - The child is deceased.
  - The child graduated, completes, or drops out from a full-time, kindergarten to 12th grade educational program or its equivalent, and the child is 18 years old.
  - There is no longer an individualized education program (IEP) under s. 115.787, Stats., in effect for the child and the child is 18 years old.
  - I am no longer supporting the child.
  - The child's parent is residing with the child and I.
  - The child is placed outside my home under a court order, voluntary placement agreement under s. 48.63, Stats., or a voluntary transition-to-independent-living agreement.
  - The child is placed into my home under a court order or a voluntary transition-to-independent-living agreement.
  - I will contact the agency prior to or within five (5) working days after the minor relative for whom a Kinship Care payment is made leaves my home.

If someone other than the applicant(s) has assisted in completing this form, by signing below you acknowledge that it is exactly as stated by applicant(s).

---

**SIGNATURE** – Person Other Than Applicant(s) That Assisted in Completing Form

---

I attest that the information provided above is truthful and accurate to the best of my knowledge.

---

**SIGNATURE** – Caregiver 1

---

**SIGNATURE** – Caregiver 2

---

**SIGNATURE** – Caregiver 3

---