

KINSHIP CARE REFERRAL FOR CHILD SUPPORT SERVICES

Use of form: This form must be used by the Kinship Care agency in making a referral to the local child support agency when a payment for Kinship Care is approved under s. 48.57(3m), Stats. Personal information you provide may be used for secondary purposes [Privacy Law, s.15.04(1)(m), Wisconsin Statutes].

Instructions: Complete this form to the extent possible and submit it to the local child support agency.

Name - County / Tribal Agency _____

Date - Kinship Care Payment Approved	Date - Kinship Care Payment Began	Amount of First Payment (If less than \$215)
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I. RELATIVE CAREGIVER

Name (Last, First, MI, Maiden) _____		Birthdate (mm/dd/yyyy) _____
Address (Street, City, State, Zip Code) _____		Telephone Number _____
Social Security Number _____	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	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) <small>(includes Indian Subcontinent origin)</small>

II. CURRENT RELATIONSHIP OF CHILD'S PARENTS TO EACH OTHER

Relationship Status
 Married Divorced Separated with court order Separated without court order
 Never married Father deceased Mother deceased Unknown

Date - If Ever Married (mm/dd/yyyy) _____	Place of Marriage (City, State) _____	
Child Support Order Currently in Effect? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Child Support Amount (If applicable) \$ _____ per _____	Child Support Being Paid <input type="checkbox"/> Yes - Regularly <input type="checkbox"/> No <input type="checkbox"/> Yes - Irregularly <input type="checkbox"/> Unknown
Paternity Established <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	County / State / Tribe of Court Case _____	Order for Medical Support in Effect? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Child Receiving Medical Assistance (MA)? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown If "Yes", provide the MA number (if known) _____		

III. CHILD'S FATHER

Name (Last, First, MI) _____		Birthdate (mm/dd/yyyy) _____
Address (Street, City, State, Zip Code) _____		Telephone Number _____
Social Security Number _____	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) <small>(includes Indian Subcontinent origin)</small>	
Father 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 _____	

IV. CHILD'S MOTHER

Name (Last, First, MI, Maiden)		Birthdate (mm/dd/yyyy)	
Address (Street, City, State, Zip Code)		Telephone Number	
Social Security Number	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 (includes Indian Subcontinent origin)	<input type="checkbox"/> Hispanic (Mexican, Puerto Rican or other Spanish culture)	
Mother 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 _____	

V. CHILD(REN) OF NAMED PARENT(S) CURRENTLY RECEIVING KINSHIP CARE BENEFITS

List only children, both of whose parents are those named on the previous page. A separate form must be completed for a child if one of his or her parents is not identified on the previous page.

1. Name (Last, First, MI, Maiden)		Birthdate (mm/dd/yyyy)	Social Security Number
Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	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 (includes Indian Subcontinent origin)	<input type="checkbox"/> Hispanic (Mexican, Puerto Rican or other Spanish culture)	
2. Name (Last, First, MI, Maiden)		Birthdate (mm/dd/yyyy)	Social Security Number
Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	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 (includes Indian Subcontinent origin)	<input type="checkbox"/> Hispanic (Mexican, Puerto Rican or other Spanish culture)	
3. Name (Last, First, MI, Maiden)		Birthdate (mm/dd/yyyy)	Social Security Number
Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	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 (includes Indian Subcontinent origin)	<input type="checkbox"/> Hispanic (Mexican, Puerto Rican or other Spanish culture)	

VI. CONFIRMATION

The above information is true to the best of my knowledge. I understand that in any child support action, the agency attorney represents the State and does not represent me.

SIGNATURE - Relative Caregiver

Date Signed

Name - Agency Contact for This Referral

Date Signed

Telephone Number