Texas Department of
Family and Protective Services

Form K-904-2115
Revised September 2023

PERMANENCY CARE ASSISTANCE REQUEST

Purpose: The prospective kinship provider (or providers) is to complete this form to request permanency care assistance benefits.

Directions: To complete this form, the prospective kinship provider (or providers) must fill out this form with identifying information to request permanency care assistance. Send this form to the foster care caseworker for submission. If the prospective kinship provider (or providers) has any questions, please refer to the child's foster care caseworker. The foster care caseworker notifies the family when permanency care assistance is approved or denied.

AGENCY USE ONLY		
Date Form Requested:	Date Form Mailed or Given:	Date Form Returned:

KINSHIP PROVIDER # 1 IDENTIFYING INFORMATION					
First Name:	Middle Name:	Last Name:			
Mailing Address Street or P.O. Box, City, State, ZIP:					
Residence home address same as mailing address?: ☐ Yes ☐ No If no, complete residence information below.					
Residence Home Address:	Apt. No. (if applicable):	City:	County:	State:	ZIP Code:
Date of Birth:	Occupation:	Telephone Number - Work:	Cell Phone:	Telephone Number - Residence:	Social Security Number:
Email Address:					

KINSHIP PROVIDER # 2 IDENTIFYING INFORMATION					
First Name:	Middle Name:	Last Name:			
Mailing Address Street or P.O. Box, City, State, ZIP:					
Residence home address same as mailing address?: ☐ Yes ☐ No If no, complete residence information below.					
Residence Home Address:	Apt. No. (if applicable):	City:	County:	State:	Zip Code:
Date of Birth:	Occupation:	Telephone Number - Work:	Cell Phone:	Telephone Number - Residence:	Social Security Number:
Email Address:					

CHILD INFORMATION					
First Name:	Middle Name:	Last Name:	Date of Birth:	Social Security Number:	Total Number of Household Members:

ASSISTANCE BEING REQUESTED

This Request Is For:

- ☐ Monthly Financial Assistance
- ☐ Medicaid
- ☐ Nonrecurring Expenses
- ☐ A Deferred Agreement

Note: Use a deferred agreement when parents of an eligible child can currently meet the child's needs but may need assistance with the child's needs in the future.

HEALTH COVERAGE

Will you have medical insurance coverage, other than Medicaid, for this child? ☐ Yes ☐ No

If Yes, complete the following Insurance Company Information section and include the insurance company name (for example, Blue Cross-Blue Shield, Champus, and so on).

Attach an additional sheet, if necessary

INSURANCE COMPANY INFORMATION			
Insurance Company Name:	Effective Date of Child's Coverage:		
Company Address:	City:	State:	ZIP Code:
Policy Number:	Group Number:	Name of Policy Holder:	Employment Related? ☐ Yes ☐ No
If employment related, give employer's name and address:			

PRIVACY STATEMENT

DFPS values your privacy. For more information, read our Privacy and Security Policy.

ACKNOWLEDGMENT

I understand that if the child is eligible for medical care coverage through Medicaid, by state law, the right to financial recovery from personal insurance and other recovery resources, or compensation for personal injuries caused by negligence or wrong doing of another, is automatically assigned to the state of Texas. This allows the state to cover costs of medical services paid by the Medicaid program.

I have been advised and understand that this request will be considered without regard to race, color, religion, creed, national origin, age, sex, disability, or political belief. I understand that I may request a fair hearing if this request is denied or is not acted upon within a reasonable time.

If this case is selected for review, I give consent for the Texas Department of Family and Protective Services (DFPS) to obtain information from any source to verify the statements I have made.

My answers to all questions and the statements I have made are true and correct to the best of my knowledge and belief.

Kinship Provider #1 Signature: **X**	Date Signed:
Kinship Provider #2 Signature: **X**	Date Signed: