



**CERTIFICATION FOR FOSTER CHILDREN**

This is to certify that I have been informed of the following requirements for coverage of a foster child in the Federal Employee’s Health Benefits Program or the District Employee’s Health Benefits Program:

- The child must be under age 26 (if the child is age 26 or older, he/she can be covered if he/she is incapable of self-support because of a disabling condition that began before age 26. I must provide documentation of this to the D.C. Department of Human Resources (DCHR);
- The child must currently live with me;
- I must currently be the primary source of financial support for the child;
- The parent-child relationship must be with me, not the biological parent. This means that I exercise parental authority, responsibility, and control. I care for, support, discipline, and guide the child. I make the decisions about the child’s education and health care; and
- I must expect to raise the child into adulthood.

I understand that if the child moves out of my home to live with a biological parent, he/she loses coverage and cannot ever again be covered as a foster child unless the biological parent dies, is imprisoned, or becomes incapable of caring for the child due to a disability, or unless I obtain a court order taking parental responsibility away from the biological parent.

This is to certify that \_\_\_\_\_ (name of child) lives with me; I am the primary source of financial support for this child; I have a regular parent-child relationship with this child, as described above; and I intend to raise this child into adulthood.

I have provided DCHR proof of my regular and substantial support for \_\_\_\_\_ (name of child) by providing more than one (1) of the following:

- Evidence of eligibility as a dependent child for benefits under other State or Federal programs;
- Proof of inclusion of the child as a dependent on the enrollee’s income tax returns;
- Canceled checks, money orders, or receipts for periodic payments from the enrollee for or on behalf of the child; or
- Evidence of goods or services which show regular and substantial contributions of considerable value.

I will immediately notify DCHR and the health benefits carrier if this child moves out of my home, or ceases to be financially dependent on me.

\_\_\_\_\_  
Print name of Subscriber

\_\_\_\_\_  
Social Security Number

\_\_\_\_\_  
Subscriber Signature

\_\_\_\_\_  
Date

Subscribed and sworn (or affirmed) before me this \_\_\_\_\_ of \_\_\_\_\_, \_\_\_\_\_  
Day Month Year

\_\_\_\_\_  
Signature of Officer

(SEAL)