STATEMENT OF CARE AND SUPERVISION / AUTHORIZATION FOR HEALTH CARE

State Form 45093 (R4 / 2-13) / CW 3319

The Department of Child Services / Probation Department in ________________________
County has responsibility for placement and care of the minor children listed below.

Said children are placed in the care and supervision of ____________________________.
(Enter foster parents / residential facility name.)

NAME OF CHILD	DATE OF BIRTH *(month, day, year)*	MEDICAID / INSURANCE POLICY NUMBER

(*See reverse side*)

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As provided for in IC 16-36-1-5, permission to authorize emergency and routine health care has been granted to the above listed resource. Any questions concerning this card should be directed to the ☐ Family Case Manager ☐ Probation Officer *(check one)* shown below.

Signature of Family Case Manager / Probation Officer	Date signed (*month, day, year*)
Printed name of Family Case Manager / Probation Officer	Telephone number ( )

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