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
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(See reverse side)

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NAME OF CHILD	DATE OF E (month, day	BIRTH MEDICAID / INSU (, year) POLICY NUME	RANCE	NAME OF CHILD	DATE OF BIRTH (month, day, year)	MEDICAID / INSURANCE POLICY NUMBER
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Printed name of Family Case Manager	/ Probation Officer	Telephone number		Printed name of Family Case Manager	r / Probation Officer Teleph	one number
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