



# INDIAN STATUS IDENTIFICATION

State Form 55407 (R / 9-18)  
DEPARTMENT OF CHILD SERVICES

**INSTRUCTIONS:** The Family Case Manager (FCM) must complete this form for each child who has membership, or may be eligible for membership, with an American Indian or Alaska Native U.S. Federally Recognized tribe. This form should be completed when obtaining family information for the Indian Child Welfare Act (ICWA) determination and continue to be reviewed and updated throughout the life of the case. The completed document must be uploaded to MaGIK and a copy provided to the local office attorney.

Case name	Case number	County
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Birth Name and All Other Known Names or Aliases	Date of Birth <i>(month, day, year)</i>	Place of Birth <i>(city, state, and/or reservation)</i>	Tribal Affiliation and Location	Enrolled In a Tribe?	Enrollment Number
Name of child <i>(first, middle, last)</i>				<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
<b>Maternal Family Information</b>					
Name of birth mother <i>(first, middle, last)</i>				<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
Name of maternal grandmother <i>(first, middle, last)</i>				<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
Name of maternal grandfather <i>(first, middle, last)</i>				<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
Name of maternal great-grandmother <i>(first, middle, last)</i>				<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
Name of maternal great-grandfather <i>(first, middle, last)</i>				<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
<b>Paternal Family Information</b>					
Name of birth father <i>(first, middle, last)</i>				<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
Name of paternal grandmother <i>(first, middle, last)</i>				<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
Name of paternal grandfather <i>(first, middle, last)</i>				<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
Name of paternal great-grandmother <i>(first, middle, last)</i>				<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
Name of paternal great-grandfather <i>(first, middle, last)</i>				<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	

Name(s) of person(s) providing information
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Have you or any members of your family ever received services from the Bureau of Indian Affairs? <i>(check one)</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
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*If yes, complete the following.*

Name	Relationship to Child	Service	Location	Date <i>(month, day, year)</i>

Have you or any members of your family ever attended an Indian school? <i>(check one)</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
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*If yes, complete the following.*

Name	Relationship to Child	Service	Location	Date <i>(month, day, year)</i>

Have you or any members of your family ever received medical treatment at an Indian Health Clinic? *(check one)*  Yes  No  Unknown

*If yes, complete the following.*

Name	Relationship to Child	Service	Location	Date (month, day, year)

Have you or any members of your family ever lived on Federal Trust land, a reservation, or a Rancheria? *(check one)*  Yes  No  Unknown

*If yes, complete the following.*

Name	Relationship to Child	Service	Location	Date (month, day, year)

Additional comments

Is the birth father named on the birth certificate for the child? *(check one)*  Yes  No      If no, was the birth father's paternity established? *(check one)*  Yes  No  Unknown      Where was paternity established? *(city, state)*

Signature of parent / client \_\_\_\_\_ Date (month, day, year) \_\_\_\_\_

Printed name of parent / client \_\_\_\_\_

Signature of Family Case Manager (FCM) / interviewer \_\_\_\_\_ Date (month, day, year) \_\_\_\_\_

Printed name of Family Case Manager (FCM) / interviewer \_\_\_\_\_