



FOSTER PARENT REQUEST FORM TO OBTAIN THE SOCIAL SECURITY NUMBER OF A CHILD IN FOSTER CARE FOR TAX PURPOSES

State Form 57304 (7-23)

DEPARTMENT OF CHILD SERVICES

INSTRUCTIONS:

- Sections one (1) through three (3) of this form are to be completed by a caregiver or former caregiver of a child who is or was in foster care.
- Sections four (4) through five (5) are to be completed by the Department of Child Services (DCS).
- This form is only to be completed by an individual who:
 - Seeks the Social Security Number (SSN) of a child in foster care, for the purpose of claiming the child as a dependent on their income taxes;
 - Provides or has provided care and supervision to the child under a court order for purposes of placement in a child in need of services case or juvenile delinquency case;
 - Provides or has provided care and supervision to the child for more than half of a calendar year or more than half of the days a child lived in the calendar year; and
 - Provided care to the child in the last eighteen (18) months.
- The individuals attesting to the statements in section three (3) must certify the attestation by providing their written signature and printed name in that section.
- If a household contains more than one (1) foster parent or primary caregiver, each caregiver must sign the attestation in section three (3).
- All information requested below must be provided and the form thoroughly completed.
- The completed form shall be submitted to FosterCareSupport@dcs.in.gov.

TO BE COMPLETED BY THE CAREGIVER

SECTION 1 – CAREGIVER / FOSTER HOME INFORMATION

1. Full legal name, caregiver A	2. Date of birth, caregiver A (month, day, year)
3. If applicable, full legal name, caregiver B	4. Date of birth, caregiver B (month, day, year)
5. Current address (number and street, city, state, and ZIP code)	
6. Current e-mail address (optional)	

SECTION 2 – REQUEST FOR CHILD SSN

7. Calendar year for which caregiver seeks to claim child as dependent (if multiple years, provide most recent completed applicable year)				
8. Complete the following for each child for who the caregiver is seeking an SSN from DCS (attach additional forms with section two (2) completed if needed)				
	Child's Full Legal Name	Child's date of birth (month, day, year)	Did child reside with the foster parent named in box 1 for more than half the calendar year?	If no, how many days did the child reside with the caregiver named in box 1 in the calendar year?
Child A			<input type="checkbox"/> Yes <input type="checkbox"/> No	
Child B			<input type="checkbox"/> Yes <input type="checkbox"/> No	
Child C			<input type="checkbox"/> Yes <input type="checkbox"/> No	
Child D			<input type="checkbox"/> Yes <input type="checkbox"/> No	

9. Additional notes regarding the request of SSNs. (optional)

SECTION 3 – ATTESTATION

By signing this attestation, I hereby affirm under penalty of perjury and pursuant to IC 31-28-6.7 that: <ol style="list-style-type: none">The information contained herein is true and accurate to the best of my knowledge and belief.I have provided care to each child named in box eight (8) as a result of the Department of Child Services or a court order placing the child with me.I am requesting the SSN of the child or children named above exclusively for the purpose of income tax.I have read and understand the Internal Revenue Service guidelines for claiming dependents.I understand that the SSN of the child or children named above is confidential and that there may be civil or criminal penalties for unauthorized disclosure of the child's SSN.		
10. Signature of caregiver A	11. Printed name	12. Date of signature (month, day, year)
13. If applicable, signature of caregiver B	14. Printed name	15. Date of signature (month, day, year)

TO BE COMPLETED BY THE DEPARTMENT OF CHILD SERVICES

SECTION 4 – APPROVAL OR DENIAL OF REQUEST

16. Complete the following for each child named in box eight (8).

	Child's Full Legal Name	Has the caregiver request for the child's SSN been approved or denied?	If the request is approved, the child's SSN (XXX-XX-XXXX)
Child A			
Child B			
Child C			
Child D			

17. Complete the following for each request denied in box sixteen (16).

	Child's Full Legal Name	Reason for denial			
		1. The child does not have an SSN or DCS does not have a record of the child's SSN.	2. It has been more than eighteen (18) months since the child resided with the individuals named in section one (1).	3. The child lived with the individuals named in section one(1) for less than half of the year and less than the majority of the days the child lived in the calendar year.	4. Other, explained in box eighteen (18).
Child A		1. <input type="checkbox"/>	2. <input type="checkbox"/>	3. <input type="checkbox"/>	4. <input type="checkbox"/>
Child B		1. <input type="checkbox"/>	2. <input type="checkbox"/>	3. <input type="checkbox"/>	4. <input type="checkbox"/>
Child C		1. <input type="checkbox"/>	2. <input type="checkbox"/>	3. <input type="checkbox"/>	4. <input type="checkbox"/>
Child D		1. <input type="checkbox"/>	2. <input type="checkbox"/>	3. <input type="checkbox"/>	4. <input type="checkbox"/>

18. Explanation for DCS's denial (*optional*)

19. Printed name of DCS employee who approved the above determination

20. Signature of DCS employee who approved the above determination

21. Date of signature (*month, day, year*)