

Information for an Additional Child						Page ___ of ___	
<p>If the Custodial Parent (CP), Guardian, or Other Noncustodial Parent (NCP) for foster care (FC) cases has more than one child with this NCP/Putative Father (PF), an LDSS-4882C form or a copy of Part III of the LDSS-4882 must be completed for each additional child.</p>							
CIN			WMS Line Number				
Name of Child	First	Middle	Last	Suffix			
SSN	- -	ITIN	- -	Date of Birth	Month/Day/Year ___/___/___		
Gender	<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Unborn Due Date ___/___/___	Name of Biological Parent	Mother: First	Middle	Last		
			Father: First	Middle	Last		
Relationship of the NCP/PF to the Child	<input type="checkbox"/> Parent <input type="checkbox"/> Stepparent <input type="checkbox"/> Putative Father						
Parents' Marital Status	Was the mother married to the father or stepfather of the child at the time of the child's birth? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown If "Yes," go to the "Order of Support Information" questions below. If "No" or "Unknown," go to the "Paternity Establishment" questions below.						
Please note that if paternity was not established for the child, a paternity affidavit must be completed.							
Paternity Establishment	Was paternity established? <input type="checkbox"/> Yes – Go to the "Paternity Establishment" questions below. You <u>do not</u> need to complete the "State of Jurisdiction" questions below. <input type="checkbox"/> No – Go to the "State of Jurisdiction" questions below. <input type="checkbox"/> Unknown – Go to the "State of Jurisdiction" questions below.						
	How was paternity established? <input type="checkbox"/> Established in Court on ___/___/___ Name of Court _____ <input type="checkbox"/> Acknowledgment of Paternity on ___/___/___			In what county, state, and country was paternity established? County _____ State _____ Country _____			
State of Jurisdiction	Where was the child conceived? State _____ Country _____						
	Did the PF provide prenatal expenses or support for the child? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown						
	Did the PF reside with the child in New York State? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown						
	Does the child reside in New York State as the result of acts or directives of the PF? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown						
Order of Support Information (Complete only if different for this child)	Is there an order of support for this child? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown If "Yes," what is the date of the order? ___/___/___				Is health insurance ordered? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		
	Obligation Amount	\$ _____ <input type="checkbox"/> Weekly <input type="checkbox"/> Every two weeks <input type="checkbox"/> Monthly <input type="checkbox"/> Twice per month <input type="checkbox"/> Other _____					
	Court that Issued the Order	<input type="checkbox"/> Family Court <input type="checkbox"/> Supreme Court <input type="checkbox"/> Other	County/State/Country		Court Docket or Index Number		
Health Care Coverage Information (Complete only if different for this child)	Does the child have health care coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown If "Yes," identify the type of coverage: <input type="checkbox"/> Private – Go to "Health Insurance Benefits" questions below. <input type="checkbox"/> Public – Go to "Public Health Care Coverage" questions below. <input type="checkbox"/> Unknown – Go to "Section B – Supporting Documentation" on page A-7.						
	Health Insurance Benefits	Who provides the child's private health care coverage? <input type="checkbox"/> CP <input type="checkbox"/> Guardian <input type="checkbox"/> NCP/PF <input type="checkbox"/> Stepparent <input type="checkbox"/> Unknown <input type="checkbox"/> Other _____					
		Name of Health Insurance Carrier		Policy Number		Group Number	
		No. Street	Floor/Apt./Suite	City		State	Zip
Public Health Care Coverage	Indicate the type of public health care coverage: <input type="checkbox"/> Medicaid <input type="checkbox"/> Family Health Plus <input type="checkbox"/> CHPlus <input type="checkbox"/> Other _____ Parent's CHPlus monthly contribution: \$ _____						

Part IV – Foster Care Information (Agency Use Only)				
Foster Care Referral	<i>The Commissioner or Designee must complete this section on behalf of the social services district (SSD) or the Office of Children and Family Services (OCFS) Commissioner for a child in Foster Care placement.</i>			
Name of Child	First	Middle	Last	Suffix
Case Information	Case Number	Case Status <input type="checkbox"/> Opening <input type="checkbox"/> Reopening <input type="checkbox"/> Changes or Updates		Date of Referral _____ / _____ / _____
Category	What is the claiming category? <input type="checkbox"/> IV-E Foster Care <input type="checkbox"/> Non-IV-E Foster Care			
Type of Placement	<input type="checkbox"/> Voluntary <input type="checkbox"/> Court Ordered	Placement Date _____ / _____ / _____	Cost of Care \$ _____ Per: <input type="checkbox"/> Day <input type="checkbox"/> Week <input type="checkbox"/> Month <input type="checkbox"/> Year	
Name of Agency, Facility, Foster Boarding Home	County	Agency Name	Type of Facility	
Placement Address	No. Street	Floor/Apt./Suite	City	State Zip
Subsidy Information	Is an adoption subsidy received on behalf of the child? <input type="checkbox"/> Yes <input type="checkbox"/> No		Does the subsidy include Medicaid? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Subsidy Information	Subsidy Amount and When It Is Paid	\$ _____ Per: <input type="checkbox"/> Week <input type="checkbox"/> Month <input type="checkbox"/> Year		
Case Manager	Name		Phone Number () Ext.	
Application for Child Support Services	<input type="checkbox"/> I am applying for Child Support Services as the Commissioner or Designee and this is a Foster Care referral. Signature of Commissioner/Designee _____ Date _____			