Washington State Health Care Authority

Tribal Foster Care Medical Request

Foster Care Medical Team (FCMT)
1-800-562-3022 Ext # 15480

□ **New "out of home"** placement
□ **Change** in **"out of home"** placement
□ **Child** returned home

Children in Tribal placements are eligible for Washington Apple Health. Tribal placements are not maintained in the DSHS FamLink system, so completion of this form is necessary to ensure medical coverage. If multiple children are placed with the same family only one form is needed. Please include a copy of the Tribal court placement paperwork.

DATE child(ren) placed: _____/_____/_____

Children's Information *(Please print)*

Name: _____

DOB: _____/_____/_____ Gender (circle): male female

SS #:_____-_____-_____

Tribal Affiliation:_____

Name: _____

DOB: _____/_____/_____ Gender (circle): male female

SS #:_____-_____-_____

Tribal Affiliation:_____

Name: _____

DOB: _____/_____/_____ Gender (circle): male female

SS #:_____-_____-_____

Tribal Affiliation: _____

Name: _____

DOB: _____/_____/_____ Gender (circle): male female

SS #:_____-_____-_____

Tribal Affiliation: _____

Placement Family Information *(Please print)*

Adult name(s):_____

_____

Relationship(s) to Child: _____

Phone: _____

Address: _____

City, State, Zip: _____

Tribe Information *(Please print)*

Tribe:_____

Social Worker Name: _____

Phone: _____

Email:_____

Please submit the completed form to:

Email: **fcmt@hca.wa.gov**

Mail: **HCA/FCMT**
P.O. Box 45534
Olympia, WA 98504

Fax: **(360) 725-1158**

Submitted by:_____

Phone: _____

Date: _____