Information for an Additional Child Page ___ of ___

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.

CIN _____ ***WMS Line Number*** _____

Name of Child	First	Middle	Last	Suffix
SSN	- -	**ITIN**	- -	**Date of Birth** Month/Day/Year ____ / ____ / ____
Gender	☐ Male ☐ Female ☐ Unborn Due Date ____ / ____ / ____	**Name of Biological Parent**	Mother: First / Middle / Last	Father: First / Middle / Last
Relationship of the NCP/PF to the Child	☐ Parent ☐ Stepparent ☐ 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? ☐ Yes ☐ No ☐ 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? ☐ Yes – Go to the "Paternity Establishment" questions below. You do not need to complete the "State of Jurisdiction" questions below. ☐ No – Go to the "State of Jurisdiction" questions below. ☐ Unknown – Go to the "State of Jurisdiction" questions below.	
	How was paternity established? ☐ Established in Court on _____ / _____ / _____ Name of Court _____ ☐ 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? ☐ Yes ☐ No ☐ Unknown	
	Did the PF reside with the child in New York State? ☐ Yes ☐ No ☐ Unknown	
	Does the child reside in New York State as the result of acts or directives of the PF? ☐ Yes ☐ No ☐ Unknown	
Order of Support Information (Complete only if different for this child)	Is there an order of support for this child? ☐ Yes ☐ No ☐ Unknown If "Yes," what is the date of the order? _____ / _____ / _____	Is health insurance ordered? ☐ Yes ☐ No ☐ Unknown
	Obligation Amount	$ _____ ☐ Weekly ☐ Every two weeks ☐ Monthly ☐ Twice per month ☐ Other _____
	Court that Issued the Order: ☐ Family Court ☐ Supreme Court ☐ 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? ☐ Yes ☐ No ☐ Unknown If "Yes," identify the type of coverage: ☐ Private – Go to "Health Insurance Benefits" questions below. ☐ Public – Go to "Public Health Care Coverage" questions below. ☐ Unknown – Go to "Section B – Supporting Documentation" on page A-7.				
	Health Insurance Benefits	Who provides the child's private health care coverage? ☐ CP ☐ Guardian ☐ NCP/PF ☐ Stepparent ☐ Unknown ☐ 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: ☐ Medicaid ☐ Family Health Plus ☐ CHPlus ☐ Other _____ Parent's CHPlus monthly contribution: $ _____			

Part IV – Foster Care Information (Agency Use Only)						
Foster Care Referral	***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.***					
Name of Child	First	Middle	Last	Suffix		
Case Information	Case Number	Case Status ☐ Opening ☐ Reopening ☐ Changes or Updates	Date of Referral _____ / _____ / _____			
Category	What is the claiming category? ☐ IV-E Foster Care ☐ Non-IV-E Foster Care					
Type of Placement	☐ Voluntary ☐ Court Ordered	Placement Date _____ / _____ / _____	Cost of Care $ _____ Per: ☐ Day ☐ Week ☐ Month ☐ 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? ☐ Yes ☐ No	Does the subsidy include Medicaid? ☐ Yes ☐ No				
	Subsidy Amount and When It Is Paid	$ _____ Per: ☐ Week ☐ Month ☐ Year				
Case Manager	Name	Phone Number ( ) Ext.				
Application for Child Support Services	☐ I am applying for Child Support Services as the Commissioner or Designee and this is a Foster Care referral. Signature of Commissioner/Designee _____ Date _____					