

LIABILITY CLAIM REPORTING FORM

(USE THIS FORM IF A CLAIM IS BEING MADE AGAINST YOU OR A FOSTER CHILD/RESPITE CARE CLIENT)

- 1. Foster Parent or Respite Care Provider _____
- 2. Street Address _____
 City _____ State _____ Zip _____ Telephone# _____
- 3. Foster Parent License # _____ Social Security # _____
- 4. Name of Foster Child or Respite Client _____
 Foster Child Date of Birth _____ (OR) Age _____ Sex _____
- 5. **SPECIFIC** date and time of incident _____
- 6. Where did incident take place? _____
- 7. Description of incident _____

- 8. **PERSONAL INJURY SECTION**
 (Complete this section only if a claim for INJURY is being made AGAINST you or the person named in number 4)
 Full Name of Injured Party _____ Telephone # _____
 Address _____
 Age _____ Sex _____ Occupation _____
 Description of Injury _____
 Physician's Name or Medical Facility _____
- 9. **PROPERTY DAMAGE SECTION**
 (Complete this section only if a claim for PROPERTY DAMAGE is being made AGAINST you or the person named in number 4)
 Name _____ Telephone # _____
 Address _____
 Description of Damaged Property _____
 Estimated Amount of Damage _____
 Where can damages be seen? _____
- 10. **WITNESS SECTION (LIST ANY WITNESSES TO THE INCIDENT)**
 Name _____ Telephone # _____
 Address _____
- 11. Other remarks or comments as to fault _____
- 12. Has loss been reported to your insurance company? _____
 If yes, name and phone # of person reported to _____

Signature

Date

PLEASE COMPLETE AND MAIL THIS FORM IMMEDIATELY TO:
RISK MANAGEMENT DIVISION
85 STATE HOUSE STATION
AUGUSTA, MAINE 04333
1-800-525-1252 or 287-3351

INSURANCE PROGRAM FOR FOSTER PARENTS AND RESPITE CARE PROVIDERS