DISTRICT OF COLUMBIA
PUBLIC SCHOOLS

FOSTER CHILD CERTIFICATION FORM

I have been informed of the following requirements for coverage of a foster child for health insurance under the District of Columbia Employees' Health Benefits (DCEHB) program and the Federal Employees' Health Benefits (FEHB) program. I am also aware of the requirements to cover a foster child as a dependent through the Option C - Family Coverage Life Insurance under the District of Columbia Employees' Government Life Insurance (DCEGLI) program and the Federal Employees' Government Life Insurance (FEGLI) program.

As such:

- The child must be unmarried and under the age of 26. (If the child is over age 26, he/she can only be covered if incapable of self-support because of a disabling condition that began before age 26. I must provide documentation of the child's disability to my employing office.)
- The child must be living with me.
- The parent-child relationship must be with me, not with the biological parent. This means that I am exercising parental authority, responsibility and control. I am caring for, supporting, disciplining, and guiding the child; and I am making the decisions about the child's education and health care.
- I must be the primary source of financial support for the child.
- I must expect to raise the child to adulthood.

I understand that if the child moves out of my home to live with a biological parent, he/she loses coverage and cannot ever again be covered as a foster child unless the biological parent dies, is imprisoned, or becomes incapable of caring for the child due to disability, or unless I obtain a court order taking parental responsibility away from the biological parent.

This is to certify that: _____lives with me and we
Full Name of Child
have a regular parent-child relationship as described above. I am the primary source of financial

support and intent to raise _____to adulthood.
Full Name of Child

I will immediately notify my employing office (and the health benefits carrier if the child is covered under FEHB) if the child marries, moves out of my home, or ceases to be financially dependent on me.

_____ _____
Print Name of Employee | Employee Social Security Number

_____ _____
Signature of Employee | Date