

**FAX TRANSMITTAL - TITLE IV-E VERIFICATION Exhibit 1**

**TO: DCF REVENUE MANAGEMENT UNIT FAX NO: (617) 542-3824**  
**For retransmission call (617) 426-4949**

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The Department of Children and Families has filed a claim for SSI benefits or is providing support for the person named below. The Social Security Administration needs to verify title IV-E benefit information for the claimant.

**PART I: TO BE COMPLETED BY SSA**

**SSA Field Office:** \_\_\_\_\_ **Fax No:** \_\_\_\_\_  
**Date of Request:** \_\_\_\_\_ **Unit Code:** \_\_\_\_\_  
**FO Telephone No:** \_\_\_\_\_ **Consumer DCF ID#:** \_\_\_\_\_  
(If available)  
**Claimant Name:** \_\_\_\_\_ **Adoptive Name:** \_\_\_\_\_  
(If available)  
**Claimant SSN:** \_\_\_\_\_ **Consumer or ADS#:** \_\_\_\_\_  
(If available)  
**Claimant DOB:** \_\_\_\_\_

1. **Has the consumer received title IV-E foster care or adoption assistance payments since the first of \_\_\_\_\_?**

**PART II: TO BE COMPLETED BY DCF RMU**

**Title IV-E Determination/Redetermination Date:** \_\_\_\_\_

**Discharge Date:** \_\_\_\_\_

2. **If answer to question 1 is yes, please provide:**

**Amount of IV-E foster care payment: \$** \_\_\_\_\_

**Are these payments funded under Section 477 of title IV-E?**

**Yes / No**

**Amount of IV-E adoption assistance payment: \$** \_\_\_\_\_

**Beginning month:** \_\_\_\_\_ **Frequency:** \_\_\_\_\_

3. Does DCF plan to transfer the child's foster care or adoption assistance from the title IV-E program to a program funded wholly by the State as assistance based on need? Yes / No
4. If yes, please give the last month in which the child will receive title IV-E benefits: \_\_\_\_\_
5. According to your records, is the child receiving any other income? Yes / No
6. If yes, what is the source of the income \_\_\_\_\_, the amount \$ \_\_\_\_\_ and the frequency? \_\_\_\_\_?

Signature \_\_\_\_\_ Date \_\_\_\_\_

Title \_\_\_\_\_