Foster Care Verification

RE: Foster Care Verification

Name: _____

D.O.B.: _____
MM/DD/YYYY

To Whom It May Concern:

This letter serves as confirmation that the above-named individual was in foster care in the State of Maryland during the timeframe referenced below.

Foster Care Placement Dates: _____ to _____
MM/DD/YYYY MM/DD/YYYY

If you have any additional questions, please contact the LDSS identified below.

_____ _____
Caseworker Name Date

_____ _____
Caseworker Signature Caseworker Email/Phone

_____
Name of Local DSS Director or Designee

_____
Local Dept. of Social Services

_____

_____

_____
LDSS Address

_____
LDSS Phone Number