DPP-1258B
(R. 05/2021)

COMMONWEALTH OF KENTUCKY
Cabinet for Health and Family Services
Department for Community Based Services
Division of Protection & Permanency

Adoption Assistance Annual Contact Form

Adoptive Parent(s) Name:

Street Address

City, State, Zip

Email Address	**Phone Number**
For use only if requesting extraordinary medical expenses **Adjusted Gross Income $_____** ****Attach Federal Income Tax Forms for continued reimbursement**	**# of Household Members (not including current foster children, if applicable)** **#_____**

Children for whom you receive adoption assistance. List birth and adoptive names.

Adoptive parents are required to notify the Cabinet of any changes of address or any other circumstances which may bring about a substantial change. You may request to renegotiate your subsidy at any time.

Adoptive parents have the right to a fair hearing on any decision to terminate or deny adoption assistance for any child with special needs. If you feel that your child has been unfairly denied assistance, contact your worker for information regarding requesting a fair hearing.

Your worker's name & phone number is _____
( ) _____

_____	_____
Adoptive Parent **Date**	**Adoptive Parent** **Date**