

## CABINET FOR HEALTH AND FAMILY SERVICES Department for Community Based Services Division of Protection and Permanency

## **Notice to Deny or Terminate Extension of Commitment**

Name	Date of Birth
<b>Delivery Date</b> □ Emailed □ Hand Delivered	Effective Date
	Action:
☐ <b><u>Denial of Services</u></b> : Your request to extend or reasons:	einstate your commitment has been denied for the following
are residing in a state-funded placement, you will lappeal this decision within 14 calendar days. Plea this decision and information on how to file a servalso includes a brief description of aftercare service	to terminate your commitment in 14 calendar days. If you be required to move out by the date of discharge, unless you se review this notice carefully as it outlines the reason(s) for ice complaint if you disagree with this decision. This notice ses that may be available to you.
Reason(s) for Termination  You have not maintained participation in o being placed on an Extended Commitment	one of the following and have remained noncompliant after Probation Contract:
<ul> <li>Enrollment and attending high scho</li> <li>Working towards a GED or its equi</li> <li>Enrollment and attending a full-time</li> <li>Employment and working full-time</li> <li>Enrollment and attending a part-time employed and working part-time (a</li> <li>Provided documentation of a medic</li> </ul>	ivalent; e post-secondary educational or vocational program;

You have not resided in your approved living arrangement and/or you did not communicate with your

caregiver or case manager regarding absence from your approved living arrangement.

<ul> <li>You have engaged in criminal activity and/or acquired criminal charges.</li> <li>You have failed to follow the rules outlined by your approved living arrangement including:</li> </ul>	
You have railed to follow the rules outlined by y	our approved fiving arrangement including:
How to Appea	l this Decision
In accordance with 922 KAR 1:320, Service Appeals, you written service complaint with the Office of the Ombude receipt of this notice, DCBS must wait to petition the condetermination on your complaint has been rendered. The response to the complainant within 30 calendar days of with the decision rendered, you have the right to request decision rendered. A request for review shall be submitted days of receipt of the written response. Upon completion written determination regarding the complaint within 30 commissioner's written determination.	sman. If a service complaint is filed within 14 days of ourt to terminate your commitment until a final ne Office of the Ombudsman shall provide a written receipt of a written complaint. If you are dissatisfied a commissioner's review of your complaint and the ted in writing to the commissioner within 10 calendar on of the review, the commissioner shall render a
For assistance with writing and filing a service complair specialist (ILS) or your guardian ad litem.	nt, you can contact your regional independent living
Service complaints should be submitted to <a href="mailto:chafee.ilp@l">chafee.ilp@l</a>	ky.gov.
Other Services You I	May be Eligible For
Request to return to care You have the right to request your 20th birthday. To request a reinstatement of common to the right to request a reinstatement of common to the right to request your 20th birthday.	
<u>Aftercare services</u> You may qualify for aftercare service available to help you during transition to independence. funds, etc. To apply for aftercare services, contact your	These services may include rental assistance, crisis
<u>Tuition waiver</u> The tuition waiver waives the cost of tu college or institution for up to 150 earned credits, or unt both part-time and full-time study and covers both under	il age 28, whichever comes first. The waiver applies to
<u>Education Training Voucher</u> The <u>Education Training</u> of assistance for any accredited post-secondary education program until age 26 or for five years, whichever comes contact your regional ILS.	onal or training program. Youth are eligible for this
<u>Health Insurance</u> You are eligible for Medicaid until ye	our 26 <sup>th</sup> birthday.
For more information about available resources and serv	vices, visit kyrise.ky.gov.
Name of Person Authorizing Action	Title
Signature	Date