REV 5/2021

CABINET FOR HEALTH AND FAMILY SERVICES
DEPARTMENT FOR COMMUNITY BASED SERVICES

TO: Commissioner or Designee

THROUGH: Adoption Branch Manager

THROUGH: SRA or Designee

THROUGH: FSOS

FROM: SSW County

DATE:

SUBJECT: Adoption Monthly Payment Exception

Child:

DOB:

DCBS Case #:

Private child placing agency (PCP) name:

Adoptive placement name:

PCP daily per diem: $ /monthly (daily rate x 365/12=$ round to nearest dollar) $

DCBS monthly subsidy (established amount): $

The difference between the requested PCP rate and the DCBS established rate: $

Describe in detail the current situation for the child, including a justification describing the necessary finances needed to meet the child's needs. Please include the supporting documentation for this to include the child's level of care (LOC), services provided to the child, and the plan of care.

Name: Email Address:

DCBS Commissioner or Designee Review

☐ Approved
☐ Denied
Other recommendations:

DCBS Commissioner Date

cc:
SRAA/SRCA
Case File