COMMONWEALTH OF KENTUCKY
Cabinet for Health and Family Services
Department for Community Based Services
Division of Child Care

Approval for Child Care Assistance

Discontinuance Date: Click or tap here to enter text.	**Benefind Case Number:**	**iTwist Number:**	**Intake ID Number:**
Date: Click or tap to enter a date.	☐ **Initial Approval**	☐ **Recertification**	☐ **Change**

APPROVAL INFORMATION

Birth Parent Approval ☐

Relative/Fictive Kin Approval ☐ **Date of Placement with Caregiver:** Click or tap to enter a date.

Child Care Enrollment Start Date:
Click or tap to enter a date.

Referral Reason:
☐ Mitigate risk and prevent maltreatment ☐ Prevent entry into care ☐ Support relative/fictive kin placement

ADULT INFORMATION

FAMILY SIZE

CAREGIVER # 1 **(Social Security #)**	**(Last Name)**	**(First Name)**	**(M.I.)**	**(Date of Birth)**
Address:		**County:**		**Citizenship:**
Telephone: **Home**	**Work**	**Cell**		
Marital Status: ☐ **Single** ☐ **Married** ☐ **Divorced** ☐ **Widow** ☐ **Separated**		**Sex:** ☐ **Male** ☐ **Female**	**Race/Ethnicity:**	
CAREGIVER #2 **(Social Security #)**	**(Last Name)**	**(First Name)**	**(M.I.)**	**(Date of Birth)**
Address:		**County:**		**Citizenship:**
Telephone: **Home**	**Work**	**Cell**		
Marital Status: ☐ **Single** ☐ **Married** ☐ **Divorced** ☐ **Widow** ☐ **Separated**		**Sex:** ☐ **Male** ☐ **Female**	**Race/Ethnicity:**	

If individual is receiving any of the below benefits, please check the appropriate box.

☐ **SNAP $** ☐ **MEDICAID** ☐ **KTAP**

INCOME

Name (Last, First, M.I.)	Employer	Type of Income (Wages, SSI, etc.)	Amount	Received (weekly, biweekly, monthly, semi-monthly or yearly

CHILD INFORMATION

Child's Name (Last, First, M.I.)	**Child's SS #**	**Birth Date (00/00/0000)**	**Sex M/F**	**Race**	**FD /PD**	**Days/week**	**Name of School (if attending)**	**Special Needs**	**Relationship to Caregiver**

PROVIDER INFORMATION	
Name:	
Address:	**Telephone**

The DCC-85 is to be forwarded to CHFS DCBS 85 inbox. DCC85@ky.gov

The need for child care has been reviewed and discussed with the client. Child Care is needed to accommodate employment, approved activities and/or the safety of children needing care. Preventive Protective Factor exists.

Care is needed: ☐ **Monday** ☐ **Tuesday** ☐ **Wednesday** ☐ **Thursday** ☐ **Friday** ☐ **Saturday** ☐ **Sunday** ☐
Type of care required: ☐ **Licensed** ☐ **Certified**

DCBS Worker Name:
Address:
City, State and Zip Code:
DCBS Worker Phone/Email:

DCBS Worker Signature: _____

FSOS NAME: _____ **FSOS Signature:** _____

JUSTIFICATION FOR REFERRAL: