

07/2020

Commonwealth of Kentucky
Cabinet for Health and Family Services
Department for Community Based Services
Division of Protection and Permanency

Camera Usage Exception Request

Date: **Agency Name:** **Foster Parent Name (if applicable):**

Provide information for the child for which the camera usage exception is being requested.

Name	DOB/Age/Sex	Case Number	DCBS SSW	Region of Case Origin

Child(ren) sharing the same bedroom? Yes No If yes, provide the name(s):

Please provide the safety concern and justification for the use of a camera in the child's bedroom.

Camera Usage Exception Request

The child must be made aware of the camera usage. Please provide documentation of the conversation along with what measures have been put into place to ensure privacy while changing clothes and other personal needs.

PCC/PCP/DCBS representative (Please Print)

PCC/PCP/DCBS Representative (Signature)

Date

SRA or Designee for Region of Case Origin (Please Print)

SRA or Designee for Region of Case Origin (Signature)

Date

SRA or Designee for Region of other Children (Please Print)

SRA or Designee for Region of other Children (Signature)

Date

Director Division of Protection and Permanency or Designee

Date

APPROVED DENIED