

COMMONWEALTH OF KENTUCKY
CABINET FOR HEALTH AND FAMILY SERVICES
DEPARTMENT FOR COMMUNITY BASED SERVICES
APPLICATION FOR SERVICES

CASE NAME:

CASE NUMBER:

I. CASE TYPE (Check one)

- NEED-MANDATED** - Includes Child or Adult Protective Services; Community Services for juveniles and their families, including Voluntary Day Treatment; Homemaker Services; Preventative Services; Alternate Care; Adoption Services; and SSBG funded Child Day Care Services for protection or prevention.
- COMMITTED OR COURT ORDERED** - Requires court commitment or court order for abused, neglected or dependent children and for juveniles; Juveniles in residential treatment facilities, group homes or day treatment and their families are included.

II. SERVICE PROVISION: All open cases receive Targeted Case Management in addition to the services indicated below:

___ Visitation	___ Support Service Aides	___ Transportation	___ Status Services
___ Social Work Counseling	___ Foster Care	___ Kinship Care	___ Child Care
___ Transition Living	___ Safety Net Services	___ Preventative Assistance	___ Adoption

OTHER: _____

III. CLIENT RIGHTS

I understand that within 30 days I shall be notified of my eligibility to receive social services. I have been assured by the Cabinet for Health and Family Services (or its designated contract agency) of its intention to comply with the provisions of the Civil Rights Act, Section 504 of the Rehabilitation Act, Americans with Disabilities Act of 1990, and Title IV-A, IV-B, IV-C, IV-E and XX of the Social Security Act regarding service programs for children, families and adults. I also understand that DCBS may bill Medicaid for services provided. I agree that the services listed above are appropriate. If I am dissatisfied with action taken or the Medicaid services authorized by DCBS, I understand I may file a written complaint. The DPP-154 (Services Appeal Request) has been provided to me for that purpose. I further understand that I may be represented by an attorney or other spokesperson at all proceedings related to the Fair Hearing process. I shall expect all information concerning me to be kept confidential in accordance with the policies of the Cabinet for Health and Family Services.

Applicant's Signature _____ Date _____

Social Service Worker's Signature _____ Date _____