DPP-154A
922 KAR 1:320
(R. 11/09)

Cabinet for Health and Family Services
Department for Community Based Services

Protection and Permanency Notice of Intended Action

Method of Delivery: ____ Mail ____ Hand Delivered Case Number: _____

To: _____
First Name M.I Last Name

_____
Address Apt. # City State Zip Code

From: _____
Name of DCBS Office Phone Number of DCBS Office

This notice applies to one or more of the following services:

____Visitation ____Support Service Aides ____Transportation ____Status Services
____Social Work Counseling ____Foster Care ____Kinship Care ____Child Care
____Transition Living ____Safety Net Services ____Preventative Asst. ____Adoption
____OTHER:_____

The Cabinet for Health and Family Services will take the following action, effective: _____
Date

_____ Deny your request for services or financial assistance.
This action is taken in accordance with the following administrative regulation or statute: _____
Reason for action: _____
_____

_____ Reduce services or financial assistance provided to you by the Cabinet for Health and Family Services.
This action is taken in accordance with the following administrative regulation or statute: _____
Reason for action: _____
_____

_____ Modify services or financial assistance provided to you by the Cabinet for Health and Family Services.
This action is taken in accordance with the following administrative regulation or statute: _____
Reason for action: _____
_____

_____ Suspend services or financial assistance provided to you by the Cabinet for Health and Family Services.
This action is taken in accordance with the following administrative regulation or statute: _____
Reason for action: _____
_____

_____ Terminate services or financial assistance provided to you by the Cabinet for Health and Family Services.
This action is taken in accordance with the following administrative regulation or statute: _____
Reason for action: _____
_____

If you are dissatisfied with the action taken, you may request an administrative hearing in accordance with 922 KAR 1:320, Service Appeals, within thirty (30) calendar days from the date of this Notice by submitting a written request (DPP-154) to the Office of Ombudsman, Performance Enhancement Branch, Quality Assurance Section, 275 East Main Street, 1E-B, Frankfort, KY 40621. Except when exempt by 45 C.F.R. 205.10(a)(6), if you receive financial assistance and request a hearing within ten (10) days of receipt of the date of this notice, your financial assistance shall continue without change pending the hearing decision. **IF YOU SUBMIT A WRITTEN REQUEST FOR AN ADMINISTRATIVE HEARING, PLEASE ATTACH A COPY OF THIS NOTICE WITH YOUR REQUEST.**

For resolution of a matter not subject to review through an administrative hearing, please contact the Office of the Ombudsman at 1-800-372-2973. If you do not wish to speak with the Office of Ombudsman, you may submit your complaint to a Service Region Administrator or designee in writing no later than thirty (30) calendar days from the date of a Cabinet action to which you object.

_____ _____
Signature of Person Authorizing Action Date (Mailed or Hand Delivered)

NOTE: This Notice shall be mailed ten (10) calendar days prior to the Cabinet's action in accordance with 45 CFR 205.10 for federally mandated programs.