

**ATTENTION TO PERSONS WHO ARE  
NOT ELIGIBLE FOR AN  
ADMINISTRATIVE HEARING:**

**FOR RESOLUTION OF A MATTER NOT  
SUBJECT TO REVIEW THROUGH AN  
ADMINISTRATIVE HEARING, YOU  
MAY CONTACT THE OFFICE OF THE  
OMBUDSMAN AT 1-800-372-2973.**

**IF YOU DO NOT WISH TO SPEAK  
WITH THE OFFICE OF THE  
OMBUDSMAN, YOU MAY SUBMIT  
YOUR GRIEVANCE IN WRITING TO A  
SERVICE REGION ADMINISTRATOR  
OR DESIGNEE NO LATER THAN 30  
DAYS FROM THE DATE OF A  
CABINET ACTION TO WHICH YOU  
OBJECT.**

**TO REQUEST AN  
ADMINISTRATIVE HEARING  
FOR APPEAL OF A CABINET  
FINDING OF CHILD ABUSE OR  
NEGLECT, PLEASE COMPLETE  
THIS FORM AND MAIL TO:**

Quality Advancement Branch  
275 East Main Street, 2E-O  
Frankfort KY 40621

**IF YOU NEED ASSISTANCE WITH  
COMPLETION OF THIS FORM, PLEASE  
CONTACT THE LOCAL OFFICE AT:**

---

**A REQUEST FOR AN  
ADMINISTRATIVE HEARING  
SHALL BE POSTMARKED WITHIN  
30 DAYS RECEIPT OF THE  
SUBSTANTIATED INVESTIGATION  
NOTIFICATION LETTER.**

**IF AVAILABLE, PLEASE SUBMIT A  
COPY OF THE SUBSTANTIATED  
INVESTIGATION NOTIFICATION  
LETTER WITH THIS FORM.**

## Request for Appeal of Child Abuse or Neglect Investigative Finding

In Accordance  
with 45 CFR 205.10,  
42 USC 5106a,  
and 922 KAR 1:480

**CABINET FOR HEALTH  
AND FAMILY SERVICES**

Department for Community  
Based Services  
275 East Main Street  
Frankfort KY 40621

**FOR V/TDD SERVICES**  
Call the CHFS Office of the  
Ombudsman  
Toll Free at 1-800-627-4702

**REQUEST FOR APPEAL OF CHILD ABUSE OR NEGLECT INVESTIGATIVE FINDING**

\_\_\_\_\_  
Name of Person Found by the Cabinet to Have Abused or Neglected a Child (Please print) \_\_\_\_\_ Date

\_\_\_\_\_  
Street/P.O. Box No. City State Zip Code

\_\_\_\_\_  
Telephone Number County of Residence

PLEASE STATE IN DETAIL THE NATURE OF THE INVESTIGATIVE FINDING AND PROVIDE THE REASON WHY YOU WISH TO DISPUTE THE CABINET'S FINDING OF CHILD ABUSE OR NEGLECT. (ADDITIONAL PAPER MAY BE USED IF NECESSARY.)


PLEASE IDENTIFY THE DATE THE SUBSTANTIATED INVESTIGATION NOTIFICATION LETTER WAS RECEIVED:

MONTH \_\_\_\_\_ DAY \_\_\_\_\_ YEAR \_\_\_\_\_

**PLEASE IDENTIFY EACH CABINET STAFF PERSON INVOLVED WITH THE SUBJECT MATTER OF YOUR APPEAL. (ADDITIONAL PAPER MAY BE USED IF NECESSARY.)**

Name:	Title, if known:
Work Address:	
City:	County:

Name:	Title, if known:
Work Address:	
City:	County:

\_\_\_\_\_  
SIGNATURE OF APPELLANT DATE

\_\_\_\_\_  
SIGNATURE OF APPELLANT'S COUNSEL, IF APPROPRIATE DATE