



**CABINET FOR HEALTH AND FAMILY SERVICES**  
**Department for Community Based Services**  
**Division of Protection and Permanency**

**Subsidized Permanent Custody Assistance Worksheet**

Caregiver(s) information:

Name of caregiver:	Name of caregiver:
Street address:	Phone number:
City, State & Zip:	
Kentucky county of case responsibility:	Caregiver(s) TWIST number:

Has the caregiver(s) reviewed the Subsidized Permanent Custody Assistance Handbook?

Caregiver(s) adjusted gross income information.

(To be utilized in determining extraordinary medical co-payment)

Adjusted gross income: \$

Number of household members:

(Include children potentially receiving SPC, exclude any additional foster children currently in the home)

Additional information:

Children for whom assistance is being requested and their daily per diem:

Child's Name: Per Diem Amount: \$

Child's Name: Per Diem Amount: \$

Child's Name: Per Diem Amount: \$

<p>Worker's Name</p> <p>Date</p> <p>Reviewed by</p> <p>Date</p>	<p>Workers Phone Number</p>
<p>Comments:</p>	