DCC-85 COMMONWEALTH OF KENTUCKY N

(R. 11/2018) Cabinet for Health and Family Services

 Department for Community Based Services

 Division of Child Care

 **Approval for Child Care Assistance**

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| **Discontinuance Date:** Click or tap here to enter text. | **Benefind Case Number:** | **TWIST Number:** | **Intake ID Number:**  |
| **Date:** Click or tap to enter a date. | [ ]  **Initial Approval** | ☐**Recertification** | [ ] **Change** |
| **APPROVAL INFORMATION** |
| **Protective Services Approval** [ ]   |
| **Preventative Services Approval** [ ]  \***Co-pay cannot be waived with Preventative Care** |
| **Date of Placement with Caregiver:** Click or tap to enter a date. | **Child Care Enrollment Start Date:** Click or tap to enter a date. |
| **CO-PAY INFORMATION** |
| **Court Ordered Co-pay** [ ]  **Amount:** $Click or tap here to enter text. |
| **Should Co-pay be waived** [ ]  Y**ES**  [ ]  **NO** **NOTE: If yes, please document justification in the child’s DCBS PROTECTIVE case plan.** |
| **ADULT INFORMATION** |
| **FAMILY SIZE**  |
| **CAREGIVER # 1****(Social Security #)** | **(Last Name)**  | (**First Name)**  | **(M.I.)** |  **(Date of Birth)** |
|  **Address:** | **County:** | **Citizenship:** |
| **Telephone:****Home** **Work** **Cell**  |
|  **Marital Status:** [ ]  **Single** [ ]  **Married** [ ]  **Divorced** [ ]  **Widow** [ ]  **Separated** |  **Sex:**[ ]   **Male** [ ]  **Female** | **Race/Ethnicity:** |
| **CAREGIVER #2****(Social Security #)** | **(Last Name)**  | **(First Name)**  | **(M.I.)**  | **(Date of Birth)** |
| **Address:** | **County:** | **Citizenship:** |
| **Telephone:**  **Home**  **Work** **Cell**  |
| **Marital Status:** [ ]  **Single** [ ]  **Married** [ ]  **Divorced**[ ]  **Widow** [ ]  **Separated** | **Sex:** [ ]  **Male** [ ]  **Female** |  **Race/Ethnicity:**   |
| **If individual is receiving any of the below benefits, please check the appropriate box.**[ ]  **SNAP $**  [ ]  **MEDICAID** [ ]  **KTAP** |

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| **INCOME** |
| **Name****(Last, First, M.I.)** | **Employer** | **Type of Income****(Wages, SSI, etc.)** | **Amount** | **Received (weekly, biweekly, monthly, semi-monthly or yearly)** |
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| **CHILD INFORMATION** |
| **Child’s Name****(Last, First, M.I.)** | **Child’s SS #** | **Birth Date****(00/00/0000)** | **Sex****M/F** | **Race** | **FD/PD** | **Days per week** | **Name of School****(if attending)** | **Special Needs** | **Relationship to Caregiver** |
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| **PROVIDER INFORMATION** |
| **Name:**  |
| **Address:**  | **Telephone:** |

[ ]  **The need for child care has been reviewed and discussed with the caregiver. Child care is needed to accommodate employment, approved activities, and/or the safety of children needing care. Preventative Protective Factor exists.**

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| **Care is needed:** [ ]  **Monday** [ ]  **Tuesday** [ ]  **Wednesday** [ ]  **Thursday** [ ]  **Friday** [ ]  **Saturday** [ ]  **Sunday**  |
| **Type of care required:** [ ]  **Licensed** [ ]  **Certified**  [ ]  **Registered**   |

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| **DCBS Worker Name:** |
| **Address:**  |
| **City, State and Zip Code:**  |
| **DCBS Worker Phone/Email:**  |

**DCBS Worker Signature:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**FSOS NAME:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **FSOS Signature:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**JUSTIFICATION FOR REFERRAL:** Click or tap here to enter text.

[ ]  **The DCC-85 is forwarded to CHFS DCBS 85 inbox:** **DCC85@ky.gov**

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