(R. 2/20)

Kentucky Department for Community Based Services

Prevention Plan

Adult Name: ______________________ **Social Service Worker** ______________________

For each risk, describe the intervention to be implemented to address the issue:		
Risk(s) identified (list all which apply):		
Intervention to reduce identified risks (list all which apply):	**Who?** (document specifics for each task)	**When?**
Observation and documentation of outcomes(who will observe and document outcomes):		
This plan is valid for thirty (30) working days from the signing date. It will expire on: **The plan may be extended voluntarily with the agreement of all parties.**		

This voluntary agreement may be revoked at any time. If a change occurs, immediately contact your Social Service Worker at ______________________ .

In case of an emergency, please call 911.

The undersigned understand this document is not a court order. It is a voluntary agreement between the signed parties. All parties listed above on the intervention must sign below. Identify your relationship with the adult on the signature line.

Adult	______________________	**Date:**	__________
Guardian	______________________	**Date:**	__________
Caretaker	______________________	**Date:**	__________
Other:	______________________	**Date:**	__________
Other:	______________________	**Date:**	__________
SSW:	______________________	**Date:**	__________