**11/2020**

**CABINET FOR HEALTH AND FAMILY SERVICES**
**DEPARTMENT FOR COMMUNITY BASED SERVICES**

To: _____ Commissioner or designee

Through: _____ Adoption Branch Manager

Through: _____ SRA or designee

Through: _____ FSOS

From: _____ SSW, _____ County

Date: _____

Subject: Adoption Monthly Payment Exception
Child: _____
DOB: _____
DCBS case #: _____
Private child placing (PCP) agency _____
Adoptive placement: _____
PCP daily per diem: $_____/ Monthly (daily rate x 365/12 = $ round to nearest dollar) $_____
DCBS monthly subsidy (established amount): $_____
Difference between the requested PCP rate and the DCBS established rate: $_____

Describe in detail the current situation for the child, including a justification describing the necessary finances needed to meet the child's needs. Please include the supporting documentation for this to include the child's level of care, services provided to the child, and the plan of care:

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Name: _____ Email address: _____

DCBS commissioner or designee review

☐ Approved
☐ Denied
Other recommendations:_____
_____
_____
_____
_____

_____
DCBS Commissioner Date

cc:
SRAA/SRCA
Case file