(R. 2/20)

Kentucky Department for Community Based Services

Prevention Plan

Family 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) business 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 must sign below. Identify your relationship to the child in the signature line.

Parent/Custodian: _____ **Date:** _____
Parent/Custodian: _____ **Date:** _____
Family Member: _____ **Date:** _____
Other: _____ **Date:** _____
Other: _____ **Date:** _____
SSW: _____ **Date:** _____