DPP-154
922 KAR 1:320
(R. 12/2019)

ATTENTION TO PERSONS WHO ARE NOT ELIGIBLE FOR AN ADMINISTRATIVE HEARING UNDER THE SERVICE APPEAL PROCESS:

FOR RESOLUTION OF A MATTER NOT SUBJECT TO REVIEW THROUGH AN ADMINISTRATIVE HEARING, YOU MAY CONTACT THE OFFICE OF THE OMBUDSMAN AT 1-800-372-2973. IF YOU DO NOT WISH TO SPEAK WITH THE OFFICE OF THE OMBUDSMAN, YOU MAY SUBMIT YOUR GRIEVANCE IN WRITING TO A SERVICE REGION ADMINISTRATOR OR DESIGNEE NO LATER THAN 30 DAYS FROM THE DATE OF A CABINET ACTION TO WHICH YOU OBJECT.

PLEASE COMPLETE A CUSTOMER SATISFACTION SURVEY THROUGH THE FOLLOWING WEB-SITE:
DCBS Customer Satisfaction Survey

TO REQUEST AN ADMINISTRATIVE HEARING FOR APPEAL OF A CABINET ACTION, PLEASE COMPLETE THIS FORM AND MAIL TO:

Quality Advancement Branch
275 East Main Street, 2E-O
Frankfort KY 40621

IF YOU NEED ASSISTANCE WITH COMPLETION OF THIS FORM, PLEASE CONTACT THE LOCAL OFFICE AT:

A REQUEST FOR AN ADMINISTRATIVE HEARING SHALL BE MAILED WITHIN 30 DAYS FROM THE DATE OF A CABINET ACTION.

IF AVAILABLE, PLEASE SUBMIT A COPY OF THE DPP-154A, "NOTICE OF INTENDED ACTION" WITH THIS FORM.

Protection and Permanency Service Appeal

In Accordance
with 45 CFR 205.10 and
922 KAR 1:320

CABINET FOR HEALTH AND FAMILY SERVICES

Department for Community Based Services
275 East Main Street
Frankfort KY 40621

FOR V/TDD SERVICES
Call the CHFS Office of the Ombudsman
Toll Free at 1-800-627-4702

PROTECTION AND PERMANENCY SERVICE APPEAL

NAME OF COMPLAINANT (PLEASE PRINT): _____ DATE: _____

ADDRESS: _____
STREET/P.O. BOX NO. CITY STATE ZIP CODE

TELEPHONE NUMBER: _____COUNTY OF RESIDENCE: _____

PLEASE STATE IN DETAIL THE NATURE OF YOUR COMPLAINT AGAINST THE DEPARTMENT FOR COMMUNITY BASED SERVICES. (ADDITIONAL PAPER MAY BE USED IF NECESSARY.)

PLEASE IDENTIFY THE DATE OF THE DISPUTED CABINET ACTION: MONTH_____ DAY_____ YEAR_____

PLEASE IDENTIFY EACH CABINET STAFF PERSON INVOLVED WITH THE SUBJECT MATTER OF YOUR APPEAL. (ADDITIONAL PAPER MAY BE USED IF NECESSARY.)

Name:	Title, if known:
Work Address:	
City:	County:

Name:	Title, if known:
Work Address:	
City:	County:

_____ _____
SIGNATURE OF COMPLAINANT DATE SIGNATURE OF AUTHORIZED REPRESENTATIVE, IF APPROPRIATE DATE