DPP-154A
922 KAR 1:320
(R. 6/2019)

Cabinet for Health and Family Services
Department for Community Based Services

Protection and Permanency Notice of Intended Action

Method of Delivery: ☐ Mail ☐ Hand Delivered Case Number: _____

To: _____
First Name M.I Last Name

_____
Address Apt. # City State Zip Code

From: _____
Name of DCBS Office Phone Number of DCBS Office

This notice applies to one or more of the following services:

☐ Visitation ☐ Support Service Aides ☐ Transportation ☐ Status Services
☐ Social Work Counseling ☐ Foster Care ☐ Kinship Care ☐ Child Care
☐ Transition Living ☐ Safety Net Services ☐ Preventative Asst. ☐ Adoption
☐ OTHER:_____

The Cabinet for Health and Family Services will take the following action, effective: _____
Date

☐ Deny your request for services or financial assistance.
This action is taken in accordance with the following administrative regulation or statute: _____
Reason for action: _____
_____

☐ Reduce services or financial assistance provided to you by the Cabinet for Health and Family Services.
This action is taken in accordance with the following administrative regulation or statute: _____
Reason for action: _____
_____

☐ Modify services or financial assistance provided to you by the Cabinet for Health and Family Services.
This action is taken in accordance with the following administrative regulation or statute: _____
Reason for action: _____
_____

☐ Suspend services or financial assistance provided to you by the Cabinet for Health and Family Services.
This action is taken in accordance with the following administrative regulation or statute: _____
Reason for action: _____
_____

☐ Terminate services or financial assistance provided to you by the Cabinet for Health and Family Services.
This action is taken in accordance with the following administrative regulation or statute: _____
Reason for action: _____
_____

If you are dissatisfied with the action taken, you may request an administrative hearing in accordance with 922 KAR 1:320, Service Appeals, within thirty (30) calendar days from the date of this Notice by submitting a written request (DPP-154) to the Office of Ombudsman, Quality Advancement Branch, 275 East Main Street, 2E-O, Frankfort, KY 40621. Except when exempt by 45 C.F.R. 205.10(a)(6), if you receive financial assistance and request a hearing within ten (10) days of receipt of the date of this notice, your financial assistance shall continue without change pending the hearing decision. IF YOU SUBMIT A WRITTEN REQUEST FOR AN ADMINISTRATIVE HEARING, PLEASE ATTACH A COPY OF THIS NOTICE WITH YOUR REQUEST.

For resolution of a matter not subject to review through an administrative hearing, please contact the Office of the Ombudsman at 1-800-372-2973. If you do not wish to speak with the Office of Ombudsman, you may submit your complaint to a Service Region Administrator or designee in writing no later than thirty (30) calendar days from the date of a Cabinet action to which you object.

_____ _____
Signature of Person Authorizing Action Date (Mailed or Hand Delivered)

NOTE: This Notice shall be mailed ten (10) calendar days prior to the Cabinet's action in accordance with 45 CFR 205.10 for federally mandated programs.