RELATIVE AND FICTIVE KIN CAREGIVER AGREEMENT

THIS AGREEMENT entered by and between the Commonwealth of Kentucky, Cabinet for Health and Family Services, Department for Community Based Services, referred to as the Cabinet; and

_____

Names and Social Security Numbers of Relative or Fictive Kin Caregiver(s), referred to as the Caregiver:

_____

(Street and No.) (City) (County) (State) (Zip Code)

_____

(telephone number) (email address)

In relation to the following named Child(ren):

_____

(Name) (Social Security No.) (Twist No.)

_____

(Name) (Social Security No.) (Twist No.)

_____

(Name) (Social Security No.) (Twist No.)

_____

(Name) (Social Security No.) (Twist No.)

Section 1. It is expressly understood and agreed by the parties to this agreement:

(a) That child(ren) is/has been in the custody of the Cabinet. If reunification with the child(ren)'s home of origin is not possible, the Caregiver shall seek permanent custody or adoption as recommended by the Cabinet;

(b) That the Cabinet is placing the child(ren) with Caregiver pursuant to state and federal law;

(c) That KRS 605.090 provides that a child committed to the Cabinet for Health and Family Services may, during the period of commitment, be placed in a suitable foster home upon conditions as the Cabinet may prescribe and subject to visitation and supervision;

(d) That the child(ren)is entitled to the following benefits while in foster care, effective as of the execution of this agreement :

i. The basic per diem as set forth in 922 KAR 1:350;

ii. Child care services while the caregiver is working at a paying job in accordance with 922 KAR 1:350; and

iii. Medicaid;

(e) That the Caregiver is subject to requirements set forth in Section 2 below;

(f) **That acceptance of the benefits described in Section 1(d) may affect eligibility for other benefits and payments including but not limited to child support, Supplemental Security Income, Kentucky Transitional Assistance Program (KTAP), Supplemental Nutrition Assistance Program (SNAP), Kinship Care, Department of Housing and Urban Development Housing Assistance (HUD), Kinship Care and the Child Care Assistance Program (CCAP). Caregiver agrees to report all payments of benefits to the appropriate agency or office; and**

(g) **That the benefits described in Section 1(d) shall cease once permanent custody is granted to the caregiver; the caregiver adopts the child(ren) or permanency is otherwise achieved;**

Section 2. The Caregiver agrees:

(a) To accept children, mutually agreeable to the parties, that are referred by the Cabinet into their home for temporary care;

(b) To provide any child(ren) with routine family life, including food, shelter, clothing, affection, life skills training, recreation, education, and opportunities for religious or spiritual development in the denomination or faith of the child, if any. The latter will be done without prejudice or penalty if the child(ren)desires these types of opportunities and access can be reasonably provided in the community of placement;

(c) To model and teach pro-social behavior, daily living skills, self-care skills, and model family roles, relationship building, and decision-making skills;

(d) To celebrate and acknowledge the child(ren)'s achievements, and support opportunities for the child(ren) to pursue his or her talents, hobbies, and interests;

(e) To permit the Cabinet social service worker to visit privately with the child(ren) and to share with the worker pertinent information about the children;

(f) To cooperate with the Cabinet in meeting all background check requirements;

(g) To complete and submit the attached Relative Placement Billing invoice for each month that the child is placed with Caregiver;

(h) To comply with the general supervision and direction of the Cabinet concerning the care of the child(ren);

(i) To ensure that child(ren)ren receive adequate care and appropriate supervision while living in the home;

(j) To use a reasonable and prudent parent standard, characterized by careful and sensible parental decisions that maintain the child's health, safety and best interest while at the same time encouraging the emotional and developmental growth of the child, that a caregiver shall use when determining whether to allow child(ren)in foster care to participate in extracurricular, enrichment, cultural, and social activities and when selecting appropriate babysitters for occasional, less than 24 hours short-term use;

(k) To comply with the Cabinet's policies when choosing respite providers.

(l) To report immediately to the Cabinet any unusual incident, change of address, sickness, accident or death of the child(ren), change in the number of people living in the home, or significant change in the home;

(m) To cooperate with the Cabinet, when contacts are arranged by the cabinet's social service worker, between the placement or child(ren) and their birth family, including visits, telephone calls or mail;

(n) To comply with the Cabinet's discipline policy which prohibits the use of corporal punishment with child(ren) placed in the custody of the cabinet;

(o) To complete pediatric abusive head trauma training within five (5) days of placement if caring for a child under the age of 5 (mandatory for fictive kin);

(p) To cooperate with the Cabinet in the handling of any grievances from clients relating to foster care services;

(q) To reimburse the Cabinet for any overpayments found as a result of fiscal audits;

(r) To receive information from the Cabinet on how to recognize and report child abuse or neglect;

(s) To comply with Cabinet's policies by not identifying child(ren) in any type of publication or public exhibit, videotaping, photographing or audiotaping a child in placement for promotional purposes or in a manner that would cause the child(ren) or family to suffer discomfort or embarrassment;

(t) To notify the Cabinet at least fourteen (14) calendar days prior to requesting that a child be removed from the home, except when an identifiable risk to the health and safety of the foster child or foster family exists;

(u) To surrender the child(ren) to the authorized representative of the Cabinet upon request;

(v) To keep confidential all personal information concerning the child(ren) or his or her birth family and comply with the Health Insurance Portability and Accountability Act (HIPAA) privacy rule to include as follows:

i. Health information regarding HIV-positive status of a child is extremely sensitive and completely confidential and shall not be disclosed to others, including agents such as babysitters, family members, or friends, except as necessary to provide health care treatment (to a health professional);

ii. All other health information of a child is confidential and shall be disclosed to others only as necessary to provide health care treatment and social services;

iii. The caregivers may receive, use, and disclose health information of a child from and to health care providers as necessary to facilitate health care treatment and social services;

iv. The caregiver will ensure that any agents to whom he provides health information possessed by the cabinet agrees to the same restrictions and conditions that apply to the caregiver;

v. The caregiver may use and disclose health information to carry out his legal responsibilities, provided that the disclosure is required by law, or provided that the caregiver obtains reasonable assurances from the person to whom the

information is disclosed that it will be held confidentially and used or further disclosed only as required by law or for the purpose for which it was disclosed to the person, and the person notifies the caregiver of any instances where the confidentiality of the information has been breached;

vi. The caregiver will not disclose health information except as permitted by this agreement. If confidentiality is breached, the caregiver will inform the cabinet of the breach and mitigate any harmful effect;

vii. The caregiver will make health information of a child available to the cabinet as requested;

viii. The Cabinet shall have the right to terminate this agreement immediately if it determines that the caregiver has violated any material term of this agreement. The caregiver will return or destroy all health information received from, or created or received by, the caregiver on behalf of the cabinet at the termination of this agreement, if feasible. If such return or destruction is not feasible, the caregiver will extend the protections of this agreement to the information;

(w) To obtain all training as may be required by the Cabinet to maintain approved caregiver status;

(x) To advocate on behalf of child(ren) and participate in required case planning conferences concerning each child placed in their home;

(y) To participate in the development and implementation of the case plan established for each child placed in their home;

(z) To cooperate with the implementation of the permanency goal established for the child(ren);

(aa) To keep information shared about child(ren) and their family confidential, unless a release is authorized by the cabinet;

(bb) To authorize medical treatment for child(ren) as necessary;

(cc) To cooperate with storing and locking ammunition separately from firearms in locations that are inaccessible to a child;

(dd) To cooperate with child support enforcement activities; and

(ee) That the duties and obligations of the caregivers under this agreement are not transferable to anyone under any circumstances, except with written consent of the cabinet.

Section 3. The Cabinet agrees to provide:

(a) Child(ren) with medical care in accordance with the policies of the cabinet;

(b) Social service worker oversight and case monitoring as needed;

(c) Counseling and supportive services to the Caregivers in relation to the child(ren);

(d) Cooperation with the Caregiver in arranging specialized services for the child(ren) such as special education, higher education, psychological services, etc. if necessary; and

(e) A basic per diem, effective as of the execution of this agreement.

Section 4. Miscellaneous

a. This agreement is effective upon date of execution by signature and submission to the Cabinet.
b. The agreement expires upon the child(ren) experiencing a placement move or attaining a permanency goal, including but not limited to, reunification with the child(ren)'s parent or home of origin, permanent custody, legal guardianship, or adoption.
c. Either party may cancel this contract upon written notice to the other party.
d. It is expressly understood and agreed that this contract revokes and supersedes any prior agreement or understanding, written or oral between the parties relating to the care of the child(ren).

I have read, or have had read to me, and understand all of the conditions stated within this agreement.

Caregiver Signature Date

Caregiver Signature Date

[Type here]

EXAMPLE

RELATIVE/FICTIVE KIN PLACEMENT BILLING INVOICE

Rev. 12/1/2017

Relative Home Name: Your NAME

Address: _____

City: _____ State: _____ Zip: _____ Phone: _____

Month/Year: APRIL 20XX County: _____

Child's Name / TWIST #	DOB	Entry Date	Perm. Custody Date*	# of Days	Rate 24.10<12 26.20>12	Total
Joe Smith	4/11		Leave Blank	# of days in month	If child under 12 multiply # of days by 24.10 and if over 12 multiply # of days by 26.20 for total	
				TOTAL		

*Enter Date Only If Permanent Custody Has Been Granted.

I hereby certify that the expenses and boarding home care specified have been furnished to the child by me, and that payment in whole or in part has not been received.

_____ _____

Relative Signature (Required) *Date*

ENTRY DATE- Date child entered your home.

[Type here]

SPECIAL EXPENSES (Senior Expenses, Birthday, Christmas,)

Name of Child	Description of Expense	Date of Expense	Amt. Paid
Nothing goes here except Birthday, Christmas and other items listed on tip sheet.			
Total Amount of Special Expenses			

NOTE: Receipts are required for all special expenses except Birthday & Christmas. Both Birthday and Christmas reimbursement occur the month of the actual day and child must be in your home on that day to receive reimbursement.

Please return to:

By mail:
Lisa Wise-Hodnett
275 E. Main St 3W-C
Frankfort, Ky. 40601

or

Scan and Email: lisa.wise-hodnett@ky.gov

RELATIVE/FICTIVE KIN PLACEMENT BILLING INVOICE

Rev. 12/1/2017

Relative Home Name: _____

Address: _____

City: _____ **State:** _____ **Zip:** _____ **Phone:** _____

Month/Year: _____ **County:** _____

Child's Name / TWIST #	*DOB*	*Entry Date*	*Perm. Custody Date**	*# of Days*	*Rate 24.10<12 26.20>12*	*Total*
				TOTAL		

Enter Date Only If Permanent Custody Has Been Granted.

I hereby certify that the expenses and boarding home care specified have been furnished to the child by me, and that payment in whole or in part has not been received.

_____ _____

Relative Signature (Required) ***Date***

Please return to:
By Mail: or Scan and Email: chfsrelativepayments@ky.gov
DAFM/Relative Payments Section
Frankfort, Ky. 40601

SPECIAL EXPENSES (Senior Expenses, Birthday, Christmas,)

Name of Child	Description of Expense	Date of Expense	Amt. Paid
Total Amount of Special Expenses			

NOTE: Receipts are required for all special expenses except Birthday & Christmas. Both Birthday and Christmas reimbursement occur the month of the actual day and child must be in your home on that day to receive reimbursement.

Please return to:

By mail:
DAFM/Relative Payments Section
275 E. Main St 3W-C
Frankfort, Ky. 40601

or Scan and Email: chfsrelativepayments@ky.gov

AUTHORIZATION FOR ELECTRONIC DEPOSIT OF PROVIDER PAYMENT

(Please print or type all information)

Enter the following provider information.. Please remember to attach a voided check.

Provider Information

Provider Name: _____

Provider SSN/FEIN: _____

Street: _____

City: _____ State: _____ Zip: _____

Telephone # _____ Contact: _____

Email Address: _____

Financial Institution Information

Bank Name: _____

Branch: _____
Or correspondent Bank (if applicable)

City: _____ State: _____ Zip: _____

Bank Routing #

Account #

Account Type (select one) ( ) Checking Account ( ) Savings Account

I, the undersigned, authorize the Commonwealth of Kentucky to initiate accounting transactions to deposit payments directly to the account indicated above and to correct any errors which may occur from the transactions. I also authorize the Financial Institution to post these transactions to that account. This authorization is to remain in force until the Commonwealth of Kentucky receives written notice of cancellation from me.

_____ _____ _____

Signature Date

_____

Name Printed

I, the undersigned, hereby cancel the authorization for the Commonwealth of Kentucky to originate electronic deposit entries into my checking/savings account. The cancellation is effective as soon as the State of Kentucky has reasonable opportunity to act upon it.

_____ _____ _____

Signature Date

_____

Name Printed

For TWIST Use

Received By _____ Date _____ Entered By _____ Date _____

CABINET FOR HEALTH AND FAMILY SERVICES
DEPARTMENT FOR COMMUNITY BASED SERVICES
Division of Administration and Financial Services

Misty Sammons
Director

275 East Main Street, 3W-C
Frankfort, KY 40621
Phone (502) 564-3427
Fax (502) 564-0328

Scott Robinson
Assistant Director

Dear Provider,

This is to advise you that the Cabinet for Health and Family Services, TWIST Payments, are now paperless. What that means is we prefer that all payments be either deposited electronically into your own personal checking/savings account or one of our EBT (Key Bank) Debit cards after your initial payment. This helps to prevent issues with lost or stolen checks, delays due to changes in addresses, and overall expediency with processing of payments.

If you choose to sign up for direct deposit into your own personal account then simply fill out the form on the back of this letter and return it, along with a voided check, via either email or mail to the address/email below. If you are using your own savings account you can send back the form with a letter from your bank with the correct routing/account information. If you choose to sign up for the Key Bank Debit Card then you would simply call the number below and we can get you enrolled in the Debit Card option. Both options still allow you to receive the payment remittance that is mailed out advising of what you are being paid for and how much each month.

If at any time you would like to change the way in which you receive your payments all you have to do is call the number below and we can do this over the phone after proper verifications are received or you can email chfsrelativepayments@ky.gov.

If you choose to use direct deposit then mail the form to:

DAFM/Relative TWIST Payments
275 E. Main Street 3W-C
Frankfort, Ky. 40601

If you choose to use the Key Bank Debit Card then just fill out the enclosed direct deposit form with your information at the top of the page and write "I WANT A DEBIT CARD" in the middle of the form and sign and date it and send it back with your initial packet and we will call and set you up when we get to your case. Please be advised that you will continue to receive your payment via paper check until such time as your case is set up with whatever option you chose.

Thank You.

RELATIVE/FICTIVE KIN TIP SHEET

Below are some helpful tools, tips and information that may be beneficial when it comes to billing and payments in regards to relative/fictive kin payments.

1. Boarding statements **MUST BE FILLED OUT MONTHLY** and should be mailed in at the end of each month, any time that last week of the month (an example has been included on how to fill that out). **You will only be sent this one invoice – make sure to MAKE COPIES OF THIS INVOICE FOR FUTURE USE TO MAIL IN MONTHLY.**
2. Please be sure to fill out in their entirety to include your full name, address and phone number along with the information for the child. This includes child's name, DOB, date of entry, the # of days in the month and the rate as well as the total.
3. If you do not have the child's TWIST # when first mailing the boarding statement that is okay, as you will receive a remittance statement with your first payment, which will have the child's DSS# on it that you can use from that point on.
4. Be sure that you sign and date your invoice forms and fill the out completely including # of days, rate and the total for the month.
5. The original packet of information that you mail back to us is taking approximately 30-45 days to process and get you set up in the system to receive your initial payment so please be patient and understand we are working diligently to get you entered and your first payment processed. For all payments that follow your initial payment, you can expect payment on your monthly invoices approximately 30 days after submission of the invoice. (e.g. – If you submit on January 31, then you will receive payment by the end of February).
6. All special expenses are to be submitted with your monthly boarding statement and can include such expenses as: (**NO OTHER RECEIPTS ARE REQUIRED TO BE SUBMITTED AND THE 2ND PAGE IS NOT NEEDED IF YOU DON'T HAVE ONE OF THESE EXPENSES TO SUBMIT**)
    a. **Birthday** - $25 (no receipt needed) and submitted the month of the child's birthday.
    b. **Christmas** - $60 (no receipt needed) and is submitted with your December boarding statement.
    c. **School Pictures** – allowed one time per year at the lowest package cost (receipt required). This is for school- aged children.
    d. **School Yearbook** – allowed one time per year and a receipt is required. This is for school- aged children.
    e. **Senior Expense** - money (for children who are seniors in HS) - $650.00 allowed and receipts are required.

Payments will come via paper check until you fill out the direct deposit form and return or call to get set up with a Key Bank Debit card. When sending back your initial packet and you want the Key Bank Debit card please just write across the form "**I WANT A DEBIT CARD**" and when I get to your packet during processing I will contact you and get you set up at that time.

Upon receiving any type of clothing letters from the Cabinet, you can do either one of two things:

1. Go to a participating store (those list will be included with your clothing letter) and purchase your clothing as a charge and the store will then send us the invoice and we pay them directly.
2. You purchase the clothes you want from the stores of your choosing and then attach your receipts for your child's clothing with the clothing letter and mail it back to the office and we will pay you directly for the allotted amount of clothing on the letter.

PLEASE NOTE THAT THE INITIAL PACKET INCLUDING AGREEMENT, VENDOR FORM (IF YOUR CHILD HAS DAYCARE), RELATIVE RESOURCE FORM, DIRECT DEPOSIT FORM AND INITIAL RELATIVE/FICTIVE KIN INVOICE SHOULD ALL BE MAILED AND/OR SCANNED AND EMAILED BACK TO THE ADDRESS PROVIDED!! AFTER THE INITIAL PACKET IS MAILED IN THEN ALL FURTHER BILLING INVOICES NEED TO BE EITHER MAILED DIRECTLY OR SCANNED AND EMAILED DIRECTLY TO THE CHFS RELATIVE PAYMENTS DEPARTMENT TO PROCESS. (NO PICTURE MAIL IS ACCEPTED FROM YOUR PHONE!!)

If you have any further questions or need clarification regarding any billing issues please feel free to contact the DAFM/Relative Payment Branch at 502-564-3427 ext. 3817 or 3820 or by email at chfsrelativepayments@ky.gov

PLEASE NOTE: You will receive a letter from the Division of Family Support stating your benefits will cease for KY Medicaid, but do not worry, it will be re-approved through the Division of Administration and Financial Management under the foster care Medicaid program.

1. Adding a Relative to the Resource Directory Form- fill this out with your information so that we can add you to our system for payment. If you answer yes to the last question that your child attends daycare then you will fill out the Vendor Form Enclosed (the vendor form is for information about your child's daycare provider) – if you answer no then you can disregard the Vendor Form.
2. Direct Deposit Form – Please either fill this out with your banking information or write on it "I want a debit card". Make sure to fill out the top portion with your information and sign the bottom either way.
3. The Agreement is a 5 page document that you fill out the first page and the last page only and send those back.
4. The last thing is the Relative Placement billing invoice and **this is the only invoice we are going to send so please make copies of this for future use..**
    A. Fill out the invoice with your name, address and the Month/Year with be the current month and year that you are submitting the packet.
    B. Make sure that you fill this form out in it's entirety including the name, DOB, date of entry, # of days (this is the # of days in the current month) the rate (if your child is under 12 the rate is 24.10 and if your child is 12 years of age or over it is 26.20) and then you multiply the # of days in the month by the rate to get your total.
    C. Sign and Date the bottom of the form and send this in with your initial packet.
5. **Please make sure that you understand that the billing invoice must be sent in on a monthly basis on the last week of month.**

Adding a Relative/Fictive Kin to the Resource Directory

COMPLETE ALL OF THE INFORMATION BELOW

Child/Children's Name(s):

TWIST Number:

Family Structure (EX – Married, Single, Unmarried Couple):

Primary Caregiver's Name:

Primary Caregiver's Date of Birth:

Primary Caregiver's Race:

Is the Primary Caregiver Hispanic:

Relationship to Child/Children:

Primary Caregiver's Social Security Number:

Relative's Complete Address: (Physical Location and Mailing Address If Different):

Relative's County:

Relative's Phone Number:

Secondary Caregiver's Name:

Secondary Caregiver's Date of Birth:

Secondary Caregiver's Race:

Is the Secondary Caregiver Hispanic:

1) **Does your child attend daycare? If so please include proof of employment (paycheck stubs for the past 4 weeks) and fill out the Daycare vendor form to send back in the packet.**

CHILDCARE VENDOR REQUEST INFORMATION

PLEASE FILL OUT THIS FORM IF YOUR CHILD ATTENDS DAYCARE. IT MUST BE FILLED OUT WITH INFORMATION REGARDING THE CHILDCARE CENTER.

Child(ren) Attending and Age:

Relative/Fictive Kin Family Name:

Are you employed? If yes please give name of employer and if you are employed full-time or part-time. If a couple is listed then please list both employers.

(Section below completed by Child Care Provider/Day Care)
CHILDCARE PROVIDER Name:

SSN/FEIN:

Tax Status (EX- INDIVIDUAL, LLC, SOLE PROPRIORTORSHIP):

Certification, License, or Registration Number:

Physical Location Address:

Mailing Address:

Phone Number (Required):

Email of Childcare Center:

Contact Person at Daycare:
County of Daycare operation: